

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30001

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Benjamin Mitchell, III				2. Date of Death Month: SEPT. Day: 19, Year: 2000				3. Time of Death 1409 PM						
	4a. Facility Name (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/A						
Funeral Director	5. Social Security Number 212-30-8536		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) October 15, 1933		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent				10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
10a. State Maryland		10b. County N/A		10e. Street and Number 528 E. 38th St.				10f. Zip Code 21218		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) district sales manager				16b. Kind of Business/Industry insurance							
17. Father's Name (First, Middle, Last) Charles Benjamin Mitchell				18. Mother's Name (First, Middle, Maiden Surname) Mildred Florence Woelper											
19a. Informant's Name/Relationship (Type, Print) Barbara Healy Mitchell/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 528 E. 38th St. Baltimore, MD 21218											
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Crematory				Date 9/25/00		20c. Location - City or Town, State Baltimore, Maryland					
21. Signature of Funeral Service Licensee John D. Mitchell				22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 21212											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MULTIPLE INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 9/19/00		28b. Time of Injury 1007 AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred DRIVER OF CAR INVOLVED IN MOTOR VEHICLE ACCIDENT					
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET				28f. Location (Street and Number or Rural Route Number, City or Town, State) 900 ARGINNE DR, BALTIMORE, MD							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier J. A. C. M.D.		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) SEPT. 20, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) SEP 22 2000				32. Registrar's Signature Benjamin B. Sparks											

Baltimore, Maryland 21215-0020

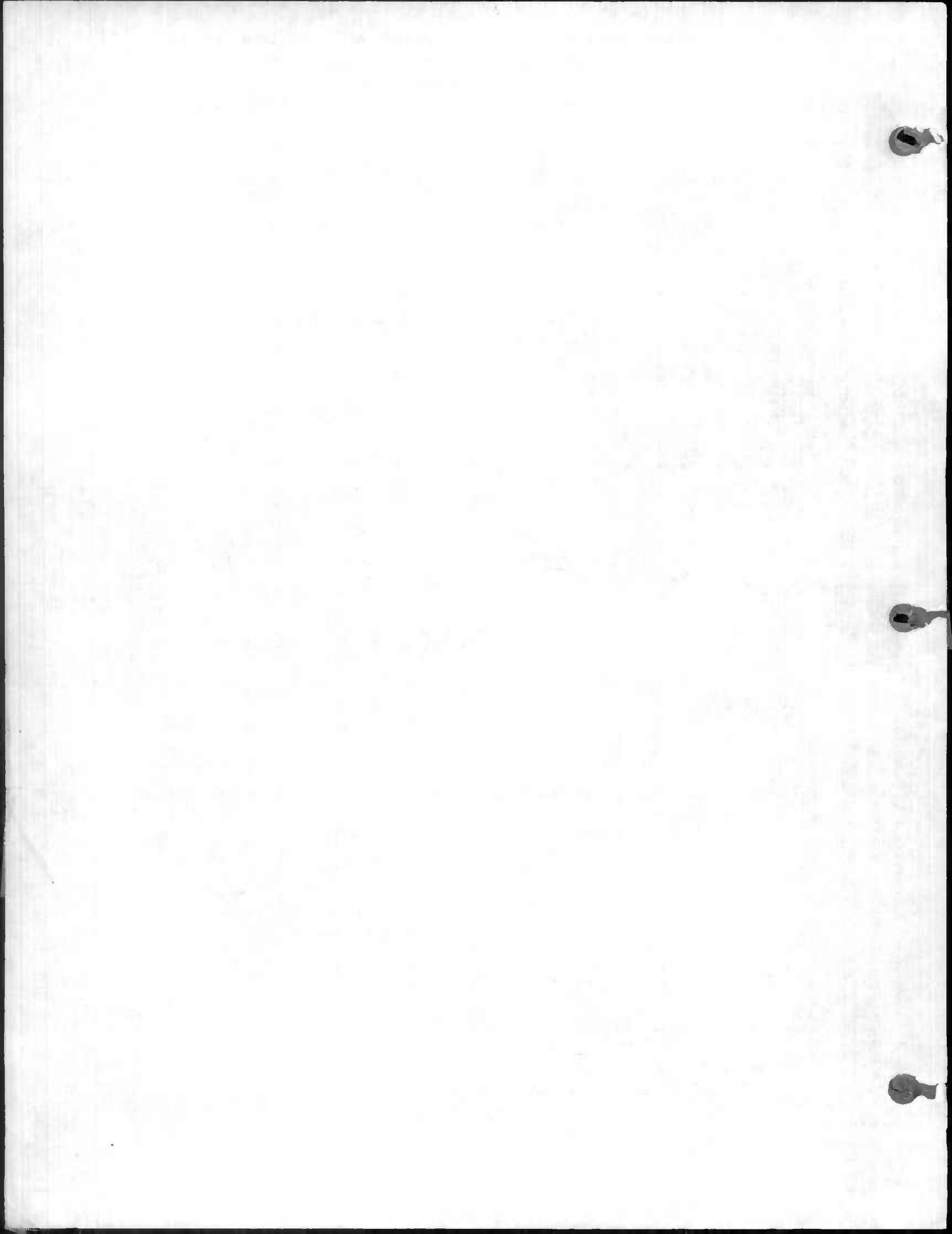
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30002

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CATHERINE MASTERS</b>		2. Date of Death Month Day Year <b>SEPTEMBER 18 2000</b>		3. Time of Death <b>9:15 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Genesis Elder Care - Severna Park</b>		4b. City, Town, or Location of Death <b>Severna Park</b>		4c. County of Death <b>Anne Arundel</b>
Funeral Director	5. Social Security Number <b>219-16-7205</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days <b>0 0</b>	If Under 24 Hrs. Hours Min. <b>0 0</b>
	8. Date of Birth (Month, Day, Year) <b>May 30, 1908</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Severna Park</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>24 Truckhouse Road</b>		10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> Collage (1-4 or 5+) <b>0</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Telephone Operator</b>		16b. Kind of Business/Industry <b>Television Station</b>		
	17. Father's Name (First, Middle, Last) <b>Frederick Vernon</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Belle Smith</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Catherine V. Grahm (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>802 Coxswain Way, Apt. 303 Annapolis, MD 21401</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		20c. Location - City or Town, State <b>9/21/00 Carney, Maryland</b>
	21. Signature of Funeral Service Licensee <b>Steven T. Bittle</b>		22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death) a. <b>DEMENTIA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>5 YEARS</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>09/21/00</b>		
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>AMUNDY MD</b>		29c. License number <b>D 2177 L</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 18 2000</b>
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SURGE P. MUNDRA MD 3001 S. HANOVER ST BALTIMORE 2124</b>				
	31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>		32. Registrar's Signature <b>[Signature]</b>		



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State of Maryland / Department of Health and Mental Hygiene

00 30003

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SOPHIA E MCGEE				2. Date of Death Month Day Year SEPT. 19 2000		3. Time of Death 1:15 PM	
	4a. Facility Name (If not institution, give street and number) 1712 Glen Curtis Road				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-26-3196		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) April 15, 1930	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10e. Street and Number 8144 Midhaven Road				10f. Zip Code 21222		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales		16b. Kind of Business/Industry Laundry Mat	
	17. Father's Name (First, Middle, Last) Cyril S Bennett				18. Mother's Name (First, Middle, Maiden Surname) Sophia E Rainger			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Keith Munshower / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 Lelangly Road Baltimore Md 21221			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cemetery		20c. Location - City or Town, State Baltimore Md	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connolly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction one day Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last History of Heart attack recent Cardiomyopathy				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Sister's house			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Shivawanda MD			
	29c. License number D52379				29d. Date signed (Month, Day, Year) 9/20/00			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Shivawanda 1124 Mace Ave Balto. MD 21221				31. Date filed (Month, Day, Year) SEP 22 2000			
	32. Registrar's Signature B. Sparks				33. Date of Death SEP 22 2000			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 30004

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Joseph Murdock</i>				2. Date of Death Month <i>09</i> Day <i>15</i> Year <i>00</i>		3. Time of Death <i>5 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Hammond Lane Nursing Facility</i>				4b. City, Town, or Location of Death <i>Brooklyn Park</i>		4c. County of Death <i>Anne Arundel</i>	
Funeral Director	5. Social Security Number <i>216-32-2139</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <i>64</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>JULY 15, 1936</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Glen Burnie</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>925 Andrews Road</i>				10f. Zip Code <i>21060</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> Collage (1-4 or 5+) <i></i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Never Worked</i>		16b. Kind of Business/Industry <i>N/A</i>		
17. Father's Name (First, Middle, Last) <i>Joseph Murdock</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Estell Shellhouse</i>				
19a. Informant's Name/Relationship (Type, Print) <i>David Wootton/Nephew</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>925 Andrews Road Glen Burnie, MD 21060</i>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Metro Crematory Inc.</i>		20c. Location - City or Town, State <i>9-20-00 Baltimore, MD</i>		
21. Signature of Funeral Service Licensee <i>Thomas Greor</i>				22. Name and Address of Facility <i>Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228</i>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>Pancreatic Cancer</i> Due to (or as a consequence of): <i>Diabetes mellitus</i> Due to (or as a consequence of): <i>sp Biliang drain placement</i> Due to (or as a consequence of):								Approximate Interval Between Onset and Death <i>6 months</i> <i>1 yr</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Chapman MD</i>		29c. License number <i>D34736</i>		29d. Date signed (Month, Day, Year) <i>9/5/00</i>
30. Name and address of person who completed causa of death (Use 23a) (Type, Print) <i>Kam AuYeung Oakwood Road Suite 100 Glen Burnie, MD 21061</i>								
31. Date filed (Month, Day, Year) <i>SEP 22 2000</i>				32. Registrar's Signature <i>Benita S Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

00 30005

AMEND: ITEM: #31 PERDVR G787 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna Mae Phillips				2. Date of Death Month Day Year September 20, 2000				3. Time of Death 3:36 p.m.	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-14-6279		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) April 14, 1923		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 3711 Echodale Avenue				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 yrs.		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Meat Packer			16b. Kind of Business/Industry Esskay Meat Company		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Frank Phillips				18. Mother's Name (First, Middle, Maiden Surname) Mary Kovach					
	19a. Informant's Name/Relationship (Type, Print) Joseph Kajzer / Friend				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 Echodale Ave. Baltimore, Maryland 21206					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Mausoleum		Date 9/23/2000		20c. Location - City or Town, State Parkville, Maryland			
	21. Signature of Funeral Service Licensee Barl L. Canapp, CFSP				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Md.				1050 York Rd.	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of): b. ASCVD Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death IMMEDIATE 3 YRS.	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS HYPERTENSION								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier [Signature]				29c. License number D18662		29d. Date signed (Month, Day, Year) 9/21/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William D. Goldner, M.D. 5901 Harford Rd. 21214									
31. Date filed (Month, Day, Year) 9-21-2000	32. Registrar's Signature [Signature]									
	SEP 22 2000									

ORIGINAL

18.0

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30006

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith May Pownall				2. Date of Death Month Day Year September 19 2000				3. Time of Death 10:10 pm	
	4a. Facility Name (If not institution, give street and number) Millennium Health & Rehabilitation				4b. City, Town, or Location of Death Edgewater				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 578-22-9831	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 13, 1916		9. Birthplace (State or Foreign Country) Pennsylvania		
	Usual Residence of Decedent									
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Edgewater				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 3765 Beach Drive Blvd.				10f. Zip Code 21037		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary			16b. Kind of Business/Industry Retail			
17. Father's Name (First, Middle, Last) George William VanMeter					18. Mother's Name (First, Middle, Maiden Surname) Marguerite Elizabeth Bach					
19a. Informant's Name/Relationship (Type, Print) (Daughter) Marguerite C. Kisamore					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3765 Beach Drive Blvd., Edgewater, MD 21037					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		Date 09/21 2000		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee Michael P. Kutta					22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)		a. Cardiac Arrhythmia Due to (or as a consequence of):						Approximate Interval Between Onset and Death Approx 5 minutes - More than 1 year.		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Atherosclerotic Cardiovascular disease Due to (or as a consequence of):								
		c. Due to (or as a consequence of):								
		d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia Atrial Fibrillation Aortic Stenosis								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Gyan chand Surana				29c. License number D 50653		29d. Date signed (Month, Day, Year) 9-20-2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN-C. SURANA 5851 - Deale Churchton Road Deale M.D. 20751										
31. Date filed (Month, Day, Year) SEP 22 2000		32. Registrar's Signature Benita B. Smith								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



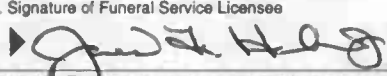
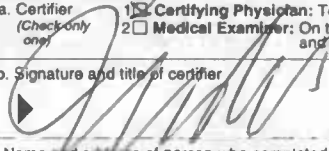
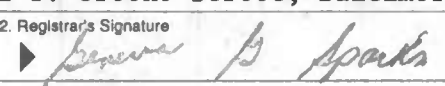
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30007

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Edwin Reincke				2. Date of Death Month Day Year September 19, 2000		3. Time of Death 9:45 P.M.									
	4a. Facility Name (If not institution, give street and number) 8401 Dogwood Road				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore									
Funeral Director	5. Social Security Number 213-28-6742	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 23, 1931		9. Birthplace (State or Foreign Country) Maryland								
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Baltimore		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	10e. Street and Number 8401 Dogwood Road				10f. Zip Code 21244		10g. Citizen of What Country? United States									
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		College (1-4 or 5+) -0-		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Project Manager		16b. Kind of Business/Industry Construction									
	17. Father's Name (First, Middle, Last) Paul Hugo Reincke				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Yeckel											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Betty J. Reincke - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8401 Dogwood Road; Baltimore, Maryland 21244											
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Park		Date 9/23/2000		20c. Location - City or Town, State Sykesville, Maryland									
	21. Signature of Funeral Service Licensee  M00869				22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road, Randallstown, MD 21133											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Respiratory Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death 15 min</td> </tr> <tr> <td>b. Small cell lung cancer</td> <td>18 mo</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	Approximate Interval Between Onset and Death 15 min	b. Small cell lung cancer	18 mo	c.		d.
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	Approximate Interval Between Onset and Death 15 min														
	b. Small cell lung cancer		18 mo													
	c.															
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier 				29c. License number D0055065		29d. Date signed (Month, Day, Year) 09/24/00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Martin Edleman 22 S. Greene Street; Baltimore, Maryland 21201																
State Registrar	31. Date filed (Month, Day, Year) SEP 22 2000		32. Registrar's Signature 													





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30008

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elijah A. Richardson</b>		2. Date of Death Month <b>SEPT.</b> Day <b>17,</b> Year <b>2000</b>		3. Time of Death <b>0050 AM</b>						
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>		4b. City, Town, or Location of Death <b>BAITIMORE</b>		4c. County of Death <b>N/A</b>						
Funeral Director	5. Social Security Number <b>247-62-8358</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>						
	8. Date of Birth (Month, Day, Year) <b>Nov. 5, 1940</b>		9. Birthplace (State or Foreign Country) <b>SC</b>								
Usual Residence of Decedent											
10a. State <b>NJ</b>		10b. County <b>Middlesex</b>		10c. City, Town or Location <b>Piscataway</b>							
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
10e. Street and Number <b>20 Buena Vista Avenue</b>			10f. Zip Code <b>08854</b>		10g. Citizen of What Country? <b>USA</b>						
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Technician</b>		16b. Kind of Business/Industry <b>Electronics</b>						
17. Father's Name (First, Middle, Last) <b>Abraham Richardson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Reid</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Rajah J. Murphy / Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1016 Walnut Street, Piscataway, NJ 08854</b>								
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glendale Cemetery</b>		20c. Location - City or Town, State <b>September 21, 2000</b> <b>Bloomfield, NJ</b>							
21. Signature of Funeral Service Licensee <b>Victor P. Doda, Jr.</b>			22. Name and Address of Facility <b>Charles L. Stevens Funeral Home, Inc.</b> <b>1501 East Fort Avenue, Baltimore Maryland 21230</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Arteriosclerotic Cardiovascular Disease</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Arteriosclerotic Cardiovascular Disease</b>	Approximate Interval Between Onset and Death	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Arteriosclerotic Cardiovascular Disease</b>	Approximate Interval Between Onset and Death									
	b. Due to (or as a consequence of):										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <b>INSPECTION</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>							
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>Margarita Korell M.D.</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>SEPT. 17, 2000</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>		32. Registrar's Signature <b>B. Sparks</b>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30009

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Sidney Shear				2. Date of Death Month Day Year SEPTEMBER 20, 2000				3. Time of Death 2:35 PM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-16-6257		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 78 Yrs.		8. Date of Birth (Month, Day, Year) April 29, 1922		9. Birthplace (State or Foreign Country) Baltimore, Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Baltimore Co.		10c. City, Town or Location Towson	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 133 Marburth Ave.				10f. Zip Code 21286	
	10g. Citizen of What Country? United States of America				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: W.W. II	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 04	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Book Keeper				16b. Kind of Business/Industry A & P Grocery Stores				17. Father's Name (First, Middle, Last) Maxwell Shear	
	18. Mother's Name (First, Middle, Maiden Surname) Blanche Pivarnik				19a. Informant's Name/Relationship (Type, Print) (Wife) Mrs. Jacqueline Elizabeth (nee Travers) Shear				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 Marburth Ave. Towson, Maryland 21286	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens				20c. Location - City or Town, State Timonium, Maryland	
	21. Signature of Funeral Service Licensee Jeffrey L. Gar				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  PNEUMONIA  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Francis Khoo				29c. License number D30263	
	29d. Date signed (Month, Day, Year) 09-20-2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21206				31. Date filed (Month, Day, Year) SEP 22 2000	
	32. Registrar's Signature B. Sparks				33. State Registrar SEP 22 2000				34. State Registrar	

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 30010

amend item 20b per fh G787 9/22/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHLEEN SCHIFF</b>		2. Date of Death Month Day Year <b>SEPTEMBER 20, 2000</b>		3. Time of Death <b>12:15PM</b>
	4a. Facility Name (If not institution, give street and number) <b>7 SLADE AVENUE #515</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>216-36-7950</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>DEC.17,1913</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10e. State <b>MD</b>	10f. County <b>BALTIMORE</b>	10g. City, Town or Location <b>BALTIMORE</b>		10h. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10i. Street and Number <b>7 SLADE AVENUE #515</b>		10j. Zip Code <b>21208</b>		10k. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REALTOR</b>		16b. Kind of Business/Industry <b>REAL ESTATE</b>		
	17. Father's Name (First, Middle, Last) <b>AUGUSTUS BINSWANGER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ADEL HEIDELBERG</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>CAROL BLUM / DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7933 EDGEWOOD FARM ROAD - FREDERICK, MD 21702</b>		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORP.</b>		20c. Location - City or Town, State <b>TOWSON, MD</b>
	21. Signature of Funeral Service Licensee <i>Michael S. ...</i>		22. Name and Address of Facility <b>SCL LEVINSON &amp; BROS., INC. 8500 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic adenocarcinoma of lung</b>				Approximate Interval Between Onset and Death <b>3 mos</b>
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <i>Mary Modelle Newman, M.D.</i>		29c. License number <b>D2790Y</b>		29d. Date signed (Month, Day, Year) <b>9-21-2000</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY MODELLE NEWMAN, M.D. 10755 FALLS RD #200 LUTHERVILLE MD 21093</b>				
	31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>		32. Registrar's Signature <i>Sparks</i>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 30011

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kikue Sasaki</b>				2. Date of Death Month <b>September</b> Day <b>20</b> , Year <b>2000</b>				3. Time of Death <b>11:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>8371 Sycamore Road</b>				4b. City, Town, or Location of Death <b>Millersville</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>213-21-1535</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>5/26, 1909</b>		9. Birthplace (State or Foreign Country) <b>Japan</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Millersville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>8371 Sycamore Road</b>				10f. Zip Code <b>21108</b>		10g. Citizen of What Country? <b>Japan</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Yosabur Sasaki</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Waki Kato</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Keiko Franks - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8371 Sycamore Road, Millersville, MD 21108</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bay View Crematory</b>		20c. Location - City or Town, State <b>9/21/00 Baltimore, MD</b>			
	21. Signature of Funeral Service Licensee <i>Kelly Gregory Fink</i> <b>Kelly Gregory Fink</b>				22. Name and Address of Facility <b>FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061</b>					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myelodysplastic Syndrome</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b> <b>Arthritis</b>									
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.	28a. Date of Injury (Month, Day, Year)									
	28b. Time of Injury <b>M</b>									
	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No									
	28d. Describe how injury occurred									
Medical Certification: To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <i>[Signature]</i>									
State Registrar	29c. License number <b>031551</b>									
	29d. Date signed (Month, Day, Year) <b>September 21, 2000</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>1600 Crain Hwy SW Suite 602 Glen Burnie md 21061</b>										
31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>										
32. Registrar's Signature <i>[Signature]</i>										

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30012

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna T. Shusta

2. Date of Death  
Month Day Year

SEPTEMBER 18, 2000 555am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

372-16-6587

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 6, 1912

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

2825 Lodge Farm Road Apt. 318

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Michael Stretanski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hudak

19a. Informant's Name/Relationship (Type, Print)

Ronald Shusta (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3535 Woodring Ave. Baltimore, Maryland 21234

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem. 9/22/2000

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pulmonary embolus

Due to (or as a consequence of):

immediate

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. deep vein thrombosis

Due to (or as a consequence of):

1 week

c. osteoarthritis

Due to (or as a consequence of):

20 years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D32783

29d. Date signed (Month, Day, Year)

9/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Adams, M.D. 7620 York Road Towson, Maryland

31. Date filed (Month, Day, Year)

SEP 21 2000

32. Registrar's Signature

B. Sparks

State  
RegistrarShuster, Anna  
Baltimore, Maryland 21215-0020

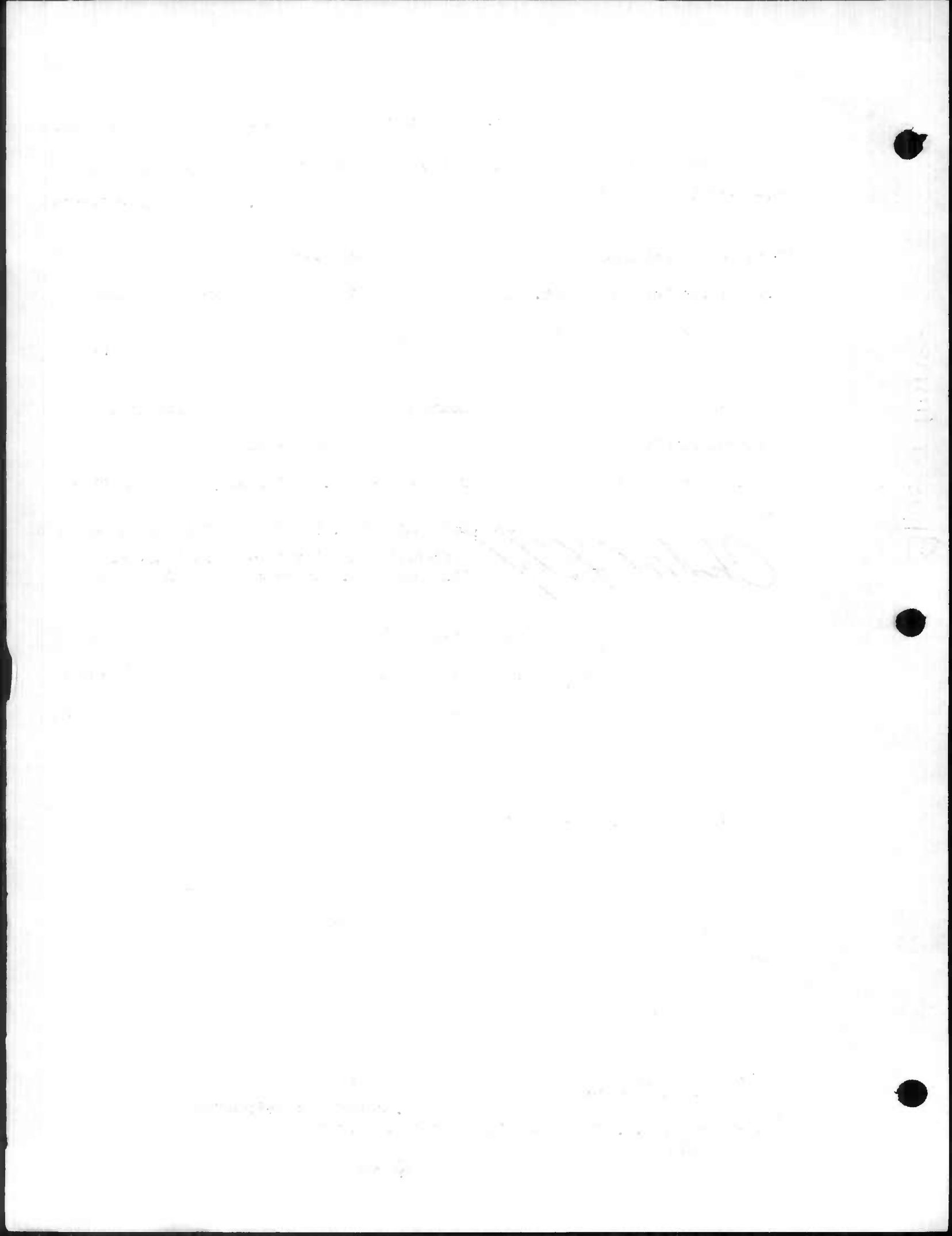
Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, F

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

### Certificate of Death

Reg. No.

00 30013

raw amend item per me G788 10/23/00 yf  
AMEND#20B PER F.H. G787 9-13-2000 JAB

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margie Ann Straw</b>		2. Date of Death Month <b>September</b> Day <b>05</b> , Year <b>2000</b>		3. Time of Death <b>8:43 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>7520 Carroll Avenue</b>		4b. City, Town, or Location of Death <b>Dundalk</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>213-62-1059</b>	6. Sex 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>47</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jun 19, 1953</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number <b>7520 Carroll Avenue</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country?	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>Home</b>		
	17. Father's Name (First, Middle, Last) <b>Unknown</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Walter Straw</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7520 Carroll Avenue, Baltimore, MD 21222</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Lawn</b>		Date <b>9-9-2000</b>	20c. Location - City or Town, State <b>Baltimore MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Kaczorowski Funeral Home, P.A. 1201 Dundalk Avenue, Baltimore, MD 21222</b>				
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>CARDIAC ARRHYTHMIA ASSOCIATED WITH SCHIZOPHRENIA</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____						
	Approximate Interval Between Onset and Death						
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier 			29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 06, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. CARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>						
	31. Date filed (Month, Day, Year) <b>SEP 13 2000</b>		32. Registrar's Signature 				
	State Registrar						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30014

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JESSE STACKHOUSE</b>		2. Date of Death Month <b>9</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>3:27 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>BOX SECOURS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>244-38-0304</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Dec 17, 1916</b>		9. Birthplace (State or Foreign Country) <b>South Carolina</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>N/A</b>
	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>4410 Elderon Ave.</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Porter</b>		16b. Kind of Business/Industry <b>Meray Hospital</b>		
	17. Father's Name (First, Middle, Last) <b>David Stackhouse</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sweetie Eady</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Annie Kemner - friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4410 Elderon Ave. Baltimore Maryland 21215</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hill Chapel Church Cem</b>		20c. Location - City or Town, State <b>9/23 Mullins, S. Carolina</b>
	21. Signature of Funeral Service Licensee <b>Kevin Parker</b>		22. Name and Address of Facility <b>Kevin A. Parker Funeral Home 3512 Frederick Ave. Baltimore, MD. 21229</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE MYOCARDIAL INFARCTION</b>				Approximate Interval Between Onset and Death
	Due to (or as a consequence of): <b>HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>				
	Due to (or as a consequence of): <b>CARDIAC ARRHYTHMIA</b>				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>ROSA R. CRUZ M.D.</b>		29c. License number <b>D0030355</b>		29d. Date signed (Month, Day, Year) <b>September 14, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROSITA R. CRUZ M.D. BOX SECOURS HOSPITAL</b>					
31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30015

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH SCOTT		2. Date of Death Month Day Year September 14, 2000		3. Time of Death 6:53 pm
	4e. Facility Name (If not institution, give street and number) Maryland General Hospital		4b. City, Town, or Location of Death Baltimore City		4c. County of Death
Funeral Director	5. Social Security Number 215-40-5553	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Apr 3, 1944		9. Birthplace (State or Foreign Country) MD		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State MD		10b. County
	10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 4 N. Central Street		10f. Zip Code 21202		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) handyman
	16b. Kind of Business/Industry hotel		17. Father's Name (First, Middle, Last) Charles L. Scott		18. Mother's Name (First, Middle, Maiden Surname) Irene Truxon
	19a. Informant's Name/Relationship (Type, Print) Md General Hospital		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 Linden Ave Baltimore, MD 21201		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201		
	23e. Pertinent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)		a. Cerebral Vascular Accident		Approximate Interval Between Onset and Death
	Due to (or as a consequence of):		b. Hypertension		
	Due to (or as a consequence of):		c.		
	Due to (or as a consequence of):		d.		
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier Benjamin Krpichak MD		29c. License number		29d. Date signed (Month, Day, Year) 9/14/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benjamin Krpichak, M.D. c/o Maryland General Hospital.					
State Registrar	31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature Benjamin Krpichak		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 30016

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALBERTA SHAYDA</b>		2. Date of Death Month Day Year <b>SEPTEMBER 19, 2000</b>		3. Time of Death <b>8:07 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>BAYVIEW HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>180-10-7487</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JULY 27, 1909</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>839 SOUTH ELLWOOD AVENUE</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>OWN HOME</b>
	17. Father's Name (First, Middle, Last) <b>JOSEPH NASTICKY</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ALBERTA HALO</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>ALBERTA EDER - DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>839 S. ELLWOOD AVENUE BALTIMORE, MD 21224</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SACRED HEART OF JESUS CEM</b>		20c. Location - City or Town, State <b>9/22 BALTIMORE, MARYLAND</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON, INC. 6224 EASTERN AVENUE BALTIMORE, MD 21224</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. <b>ANEMIA</b> Due to (or as a consequence of): b. <b>GASTROINTESTINAL BLEEDING</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					<b>SIX MONTHS</b>  <b>SIX MONTHS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HEMORRHOIDS</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>M.D. INTERN</b>		29c. License number <b>21022</b>	29d. Date signed (Month, Day, Year) <b>SEPTEMBER 19, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ERIC SAMSTAD, 4940 EASTERN AVENUE</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 2 12000</b>		32. Registrar's Signature 		

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30017

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>John Stansbury</u>		2. Date of Death Month <u>9</u> Day <u>11</u> Year <u>00</u>		3. Time of Death <u>1 27 p</u>
	4a. Facility Name (If not institution, give street and number) <u>Alice Manor Nursing Home</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death
Funeral Director	5. Social Security Number <u>215-74-4160</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>93</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>Dec 18, 1907</u>		9. Birthplace (State or Foreign Country) <u>unk</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County		10c. City, Town or Location <u>Baltimore</u>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10a. Street and Number <u>2095 Rockrose Ave</u>			10f. Zip Code <u>21211</u>		10g. Citizen of What Country? <u>USA</u>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <u>unk</u> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>white</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>unk</u> College (1-4 or 5+) <u>unk</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>unk</u>		16b. Kind of Business/Industry <u>unk</u>
17. Father's Name (First, Middle, Last) <u>unk</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>unk</u>		
19a. Informant's Name/Relationship (Type, Print) <u>unk</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>unk</u>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <u>in state</u>			20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee <u>Donald S. Wade</u> Director			22. Name and Address of Facility <u>State Anatomy Board 655 W. Baltimore Street</u> <u>Baltimore, MD 21201</u>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <u>cardiopulmonary arrest</u> Due to (or as a consequence of):					
b. <u>end stage Dementia</u> Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<u>Cerebrovascular accident, DM,</u>					
<u>Schizophrenia.</u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Donald S. Wade M.D.</u>		29c. License number <u>D-20146</u>		29d. Date signed (Month, Day, Year) <u>9/11/00</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>HEMALATA DEYADOSS 1014 PLEASANT VALLEY DR, BALTO, MD</u>					
31. Date filed (Month, Day, Year) <u>SEP 25 2000</u>		32. Registrar's Signature <u>B. Sparks</u>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30018

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ESTELLE M. SyPULA</b>				2. Date of Death Month <b>SEPT</b> Day <b>14</b> Year <b>2000</b>				3. Time of Death <b>4:00 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>JH BMC</b>				4b. City, Town, or Location of Death <b>BALTO</b>				4c. County of Death <b>BALTO CITY</b>		
Funeral Director	5. Social Security Number <b>219 01 0155</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b>		8. Date of Birth (Month, Day, Year) <b>04 03 1913</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>N/A</b>		
To Be Completed by Funeral Director	10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
	10e. Street and Number <b>829 S. Decker Avenue</b>				10f. Zip Code <b>21224</b>				10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Home</b>		
	17. Father's Name (First, Middle, Last) <b>Lukasz Malimowski</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Automima Zalimski</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Ballisterie</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>829 S. Decker Avenue, Baltimore, MD 21224</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Rosary Cem.</b>		Date <b>09/18/2000</b>		20c. Location - City or Town, State <b>Baltimore MD</b>				
	21. Signature of Funeral Service Licensee <b>Charles Kaczorowski</b>				22. Name and Address of Facility <b>Kaczorowski Funeral Home, P.A.</b> <b>1201 Dundalk Avenue, Baltimore, MD 21222</b>						
	23a. Part I. Enter the disease, or combination of diseases, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Ischemic heart disease</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>5 yrs</b>										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>dementia, chronic lung disease, menia</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Matthew McNabney MD</b>		29c. License number <b>D 45757</b>		29d. Date signed (Month, Day, Year) <b>SEP 14, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MATTHEW MCNABNEY 5505 HOPKINS BAYNES CIRCLE BALTIMORE 21224</b>		31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>				32. Registrar's Signature <b>Brian P. Sparks</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30019

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jay Howard Shunk III						2. Date of Death Month Day Year September 20 2000			3. Time of Death 12:00 P.M.	
	4a. Facility Name (If not Institution, give street and number) 7919 31st Street						4b. City, Town, or Location of Death Rosedale			4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-30-6592		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Sept 14 1935
	9. Birthplace (State or Foreign Country) MD										
Usual Residence of Decedent											
10a. State MD		10b. County Baltimore		10c. City, Town or Location Rosedale				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 7919 31st Street				10f. Zip Code 21237				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1958-1960			13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Tool Maker				16b. Kind of Business/Industry Western Electric			
17. Father's Name (First, Middle, Last) Jay Howard Shunk, Jr.						18. Mother's Name (First, Middle, Maiden Surname) Carlotta Feeser					
19a. Informant's Name/Relationship (Type, Print) Marlene Shunk/Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7919 31st Street Baltimore, MD 21237					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery				Date 9-25-00		20c. Location - City or Town, State Baltimore, MD	
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Cyach/Rosedale Funeral Home 1211 Chesaco Avenue, Baltimore MD 21237					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>METASTATIC Laryngeal Cancer</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 						29c. License number D33551		29d. Date signed (Month, Day, Year) Sept 20, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Auerbach, 9000 Fenwick St, Baltimore 21237											
31. Date filed (Month, Day, Year) SEP 22 2000											
32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30020

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William B. Smith

2. Date of Death

Sept 15, 2000

3. Time of Death

10:30 P.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health Center Of North Arundel Glen Burnie ANNE Arundel

4b. City, Town, or Location of Death

4c. County of Death

5. Social Security Number

215-10-9423

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth (Month, Day, Year)

June 3, 1905

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4049 Brummel Rd.

10f. Zip Code

21122

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dry Dock Co.

16b. Kind of Business/Industry

ShipYard

17. Father's Name (First, Middle, Last)

William B. Hawkins

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Lela Smith Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4049 Brummel Rd, Pasadena, Maryland 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

9/20/00

20c. Location - City or Town, State

Pasadena, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Estep Brothers Funeral Ser, P.A.  
1300 Eutaw Place, Baltimore, Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Dehydration

Approximate Interval Between Onset and Death

2 hrs.

b.

Due to (or as a consequence of):

abdominal wall Abscess

1 hr.

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D31322

29d. Date signed (Month, Day, Year)

9/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TRADEED GARGAL 4304 MTN. RD., PASADENA, MD 21122

31. Date filed (Month, Day, Year)

SEP 22 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#3 per PHYG790 12/14/2000 EW

## Certificate of Death

Reg. No.

00 30021

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Russell Lee Taylor, Sr.				2. Date of Death Month Day Year Sept. 12, 2000		3. Time of Death 11:06 pm	
	4a. Facility Name (If not institution, give street and number) 756 214th Street				4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 220.09.6556		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) May 24, 1919	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Pasadena	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 756 214 St.		10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman		16. Kind of Business/Industry Tate Architecture			
	17. Father's Name (First, Middle, Last) James Lee Taylor				18. Mother's Name (First, Middle, Maiden Surname) Christena Mueller			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Frances Taylor- Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 756 214th Street Pasadena, MD 21122			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		20c. Location - City or Town, State Elkridge, MD		20d. Date 9/15	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge Mem. Park 7250 Washington Blvd. Elkridge, MD 21075			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>adenocarcinoma lung</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate interval Between Onset and Death 2mo
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D21613		29d. Date signed (Month, Day, Year) 9/15/00	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loraine Dailey, M.D. 8096 Edwin Raynor Blvd., S.E., Pasadena, Md.							
	31. Date filed (Month, Day, Year) SEP 22 2000				32. Registrar's Signature <i>[Signature]</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30022

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert C. Taylor

2. Date of Death

Month Day Year  
September 20 2000

3. Time of Death

0045

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

242-34-7354A

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 22, 1927

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10e. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1130 Mainsail Drive

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electronics Engineer

16b. Kind of Business/Industry

Electronics

17. Father's Name (First, Middle, Last)

Robert Ross Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Mary Conley

19a. Informant's Name/Relationship (Type, Print)

Noriko E. Taylor (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1130 Mainsail Drive, Annapolis, MD 21403

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Data

09/21  
2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Severe Aortic Stenosis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1-2m

b.

ATHEROMATOUS DISEASE of Aorta

Due to (or as a consequence of):

4-5y

c.

ARTERIOSCLEROTIC Cerebrovascular Disease

Due to (or as a consequence of):

4-5y

d.

(R) CVA with seizure disorder

4-5y

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension, Gross Hematuria, Benign Prostatic Hypertrophy, Abdominal Pain of unknown etiology

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicida 4 ☐ Homicida

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31997

29d. Date signed (Month, Day, Year)

9/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW GORDON MD 2003 Medical Parkway Ste 100 ANNAPOLIS, MD 21401

31. Date filed (Month, Day, Year)

SEP 22 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30023

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Marshall Williams, Jr.

2. Date of Death

September 16, 2000

3. Time of Death

10:30pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

5. Social Security Number

214-20-1022

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 7, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 Somers Court

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Self-employed

16b. Kind of Business/Industry

HVAC

17. Father's Name (First, Middle, Last)

Charles Marshall Williams, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Carolyn Edith Talbott

19a. Informant's Name/Relationship (Type, Print)

Alice V. Williams/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Somers Court, Cockeysville, MD 21030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore-Washington Crematory

Data

9/19/00

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia Road, Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
8 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

9/19/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 22 2000

32. Registrar's Signature

Beneva B Sparks

ORIGINAL

September 16, 2000 10:30 p.m.  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
206A.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Charles Marshall Williams  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30024

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES H. WOODEN</b>				2. Date of Death Month <b>09</b> Day <b>21</b> Year <b>00</b>		3. Time of Death <b>6:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HERITAGE CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>717-09-7881</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JAN 29 1919</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>ESSEX</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>38 BACK RIVER NECK ROAD</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b>		College (1-4 or 5+) <b>CUSTODIAN</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CUSTODIAN</b>		16b. Kind of Business/Industry <b>BOARD OF EDUCATION BALTIMORE CO.</b>	
	17. Father's Name (First, Middle, Last) <b>JAMES A. WOODEN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY WALKER</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Theresa C. Wooden/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>38 BACK RIVER NECK RD., BALTO., MD 21221</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HOLLY HILLS MEMORIAL</b>		20c. Location - City or Town, State <b>9-26-00 MIDDLE RIVER, MARYLAND</b>		21. Signature of Funeral Service Licensee 	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PROSTATE CANCER</b> Due to (or as a consequence of): <b>CEREBROVASCULAR ACCIDENT</b> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>M-Unni. MD</b>		29c. License number <b>D51090</b>		29d. Date signed (Month, Day, Year) <b>SEP, 21, 00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MOORKATH UNNI. MD 2112 BELAIR RD, #9, FALLSTON</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>		32. Registrar's Signature  <b>MD 21047</b>					



John W. Miller

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #10F PER F.H. G787 92200 WP

Certificate of Death

Reg. No. 00 30025

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Naomi Ruth Whitaker				2. Date of Death Month Day Year September, 20 2000		3. Time of Death 7:45 P	
	4a. Facility Name (If not institution, give street and number) Future Care Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 241-52-5947		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) 11/13/1933	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <del>1</del> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 3402 Rockdale Court		10f. Zip Code <del>21214</del> 21244		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Textile			
	17. Father's Name (First, Middle, Last) Mangrum Whitaker				18. Mother's Name (First, Middle, Maiden Surname) Josephine Johnson			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lethella Campbell / Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Rockdale Court, Baltimore, Maryland 21214			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cemetery		20c. Location - City or Town, State 09/23/00 Landsdowne, Maryland		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Metastatic breast cancer</u> Due to (or as a consequence of): b. <u>Metastatic Colonic Cancer</u> Due to (or as a consequence of): c. <u>Diabetes mellitus</u> Due to (or as a consequence of): d. <u>Hypertension</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number D30115		29d. Date signed (Month, Day, Year) 9/20/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T. Ohiokepehimo 2600 Liberty Hill Ave Balt, MD 21215							
State Registrar	31. Date filed (Month, Day, Year) SEP 21 2000		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30026

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN WHITE</b>		2. Date of Death Month <b>September</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>5.00 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL</b>		4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>214-72-4681</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>43</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Apr 8, 1957</b>		9. Birthplace (State or Foreign Country) <b>DC</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>9109 Liberty Road</b>			10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>delivery</b>		16b. Kind of Business/Industry <b>newspaper</b>
17. Father's Name (First, Middle, Last) <b>Leslie A. White</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mabel E. Cooksly</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Terry Dement/sister</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Box 1087 Waldorf, MD 20604</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Nema of cemetery, crematory or other place) <b>in state</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)					
a. <b>SEPSIS</b> Due to (or as a consequence of):					
b. <b>ACUTE RENAL FAILURE</b> Due to (or as a consequence of):					
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Joginder P Mehta M.D.</b>		29c. License number <b>D41410</b>		29d. Date signed (Month, Day, Year) <b>September 19th, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN MD 21133.</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <b>Beverly S Sparks</b>			

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30028

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arthur J. Wohl</b>		2. Date of Death Month <b>SEPTEMBER</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>8:27 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>115-24-3100</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Dec. 9, 1932</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Odenton</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>525 Gladhill Road</b>			10f. Zip Code <b>21113</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korea Vietnam</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>SFC</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SFC</b>		16b. Kind of Business/Industry <b>US Army</b>
17. Father's Name (First, Middle, Last) <b>Edward Wohl</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Murphy</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Beverly M. Wohl (Wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>525 Gladhill Road, Odenton, MD 21113</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Our Lady of the Fields</b>		20c. Location - City or Town, State <b>2000 Millersville, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>METASTATIC LUNG CARCINOMA</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>6 MONTHS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATHEROSCLEROSIS</b> <b>DIABETES MELLITUS</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D 0051852</b>		29d. Date signed (Month, Day, Year) <b>9/19/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID A. BRINKER, M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204</b>					
31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>		32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30029

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM EUGENE WAGNER</b>				2. Date of Death Month Day Year <b>SEPTEMBER 18 2000</b>				3. Time of Death <b>0700</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY HOSPITAL</b>				4b. City, Town, or Location of Death <b>COLUMBIA</b>				4c. County of Death <b>HOWARD</b>	
Funeral Director	5. Social Security Number <b>217-12-1009</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 26, 1922</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Howard County</b>		10c. City, Town or Location <b>Marriottsville</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>12105 Old Frederick Road</b>				10f. Zip Code <b>21104</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanical Clerk</b>				16b. Kind of Business/Industry <b>Tool &amp; Die</b>		
17. Father's Name (First, Middle, Last) <b>Charles Walter Wagner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Marie Eisberg</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Betty J. Francis (Sister)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8216 Pleasant Plains Road, Towson, Maryland 21286</b>						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>				20c. Location - City or Town, State <b>9/20/2000 Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Martin D. Lawson</b>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>Atherosclerotic Cardiovascular Disease</u></b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Schizophrenia</b>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <b>partial</b> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicida 4 <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Dennis J. Chute</b>				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 19, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>				32. Registrar's Signature <b>Dennis J. Chute</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30030

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAWRENCE WALKER</b>		2. Date of Death Month Day Year <b>SEPTEMBER 16, 2000</b>		3. Time of Death <b>5:45pm</b>
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>250-30-5165</b>	6. Sex <b>M</b> <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>3/10/25</b>		9. Birthplace (State or Foreign Country) <b>S.C.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		
	10b. County		10c. City, Town or Location <b>Baltimore</b>		
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>128 South Carey Street</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>EIGHTH GRADE</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PASTOR</b>
	16b. Kind of Business/Industry <b>Church</b>				
	17. Father's Name (First, Middle, Last) <b>Leslie Walker</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Rebecca Walker</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Sylvester Walker Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>128 S. Carey St, Baltimore, Maryland 21223</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Western Star Cem.</b>		20c. Location - City or Town, State <b>9/23/00 Catonsville, Md.</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. MULTIPLE CEREBROVASCULAR INFARCTS</b> Due to (or as a consequence of): <b>b. END STAGE RENAL DISEASE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTIPLE MYELOMA</b> <b>MYOCARDIAL INFARCTS</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>Leslie Belloso</b>			
29c. License number <b>13117</b>		29d. Date signed (Month, Day, Year) <b>September 16, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>UNIVERSITY OF MARYLAND HOSPITAL 22 S. GREENE ST. BALTIMORE MD 21201</b>		31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>			
32. Registrar's Signature 					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30031

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Shirley June Andreae				2. Date of Death Month Day Year Sept 2, 2000		3. Time of Death 7:30 pm		
	4a. Facility Name (If not institution, give street and number) 550 Lucia Avenue				4b. City, Town, or Location of Death Baltimore		4c. County of Death		
Funeral Director	5. Social Security Number 214-24-0036		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Nov 30, 1928	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
10a. State Maryland		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 550 Lucia Avenue				10f. Zip Code 21229		10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Earl Anders				18. Mother's Name (First, Middle, Maiden Surname) Florence Hildebrandt					
19a. Informant's Name/Relationship (Type, Print) Clair Nottingham, daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 670 Deep Run Rd, Westminster, MD 21158					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremations		20c. Location - City or Town, State Hampstead, MD			
21. Signature of Funeral Service Licensee M00723 Stewart W. Elmer				22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>ASPIRATION PNEUMONIA</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 1 MONTH									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>									
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier Christina L. Combs				29c. License number 00025544		29d. Date signed (Month, Day, Year) SEPT. 5, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINE L. COMBS RD 5411 OLD FREDERICK RD #18 BALTIMORE, MD 21229									
31. Date filed (Month, Day, Year) SEP 08 2000				32. Registrar's Signature Jennifer B. Sparks					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 29c, 09/07/2000

State of Maryland / Department of Health and Mental Hygiene

00 30032

Per Carroll County, wjl

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Jornne Arnold</u>				2. Date of Death Month <u>September</u> Day <u>5</u> Year <u>2000</u>				3. Time of Death <u>2:10 P</u>		
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical System</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death <u>Baltimore CITY</u>		
Funeral Director	5. Social Security Number <u>217-12-1574</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>77</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>11/5/1922</u>		9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		
	Usual Residence of Decedent				10a. State <u>MD.</u>				10b. County <u>CARROLL</u>		10c. City, Town or Location <u>FINKSBURG</u>
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <u>1509 MARIE CT.</u>				10f. Zip Code <u>21048</u>		10g. Citizen of What Country? <u>USA.</u>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>7</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOUSEWIFE</u>				16b. Kind of Business/Industry <u>HOMEMAKER</u>			
17. Father's Name (First, Middle, Last) <u>WALTER C. COOK</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>EVIA BROWN</u>					
19a. Informant's Name/Relationship (Type, Print) <u>JAMES F. ARNOLD -HUSBAND</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1509 MARIE CT., FINKSBURG, MD. 21048</u>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>EVERGREEN MEM.GARDENS</u>				20c. Location - City or Town, State <u>9/9/00 FINKSBURG, MD.</u>			
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>FLETCHER FUNERAL HOME</u> <u>254 E. MAIN ST., WESTMINSTER, MD. 21157</u>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>stroke</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <u>48 hrs.</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28a. Place of Injury - At home, term, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <u>[Signature] MD</u>						29c. License number <u>P14636</u> <u>AN176135413194</u>		29d. Date signed (Month, Day, Year) <u>9/5/00</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Ann Helms 22 Greene St. Baltimore MD 21201</u>											
31. Date filed (Month, Day, Year) <u>SEP 07 2000</u>				32. Registrar's Signature <u>[Signature]</u>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



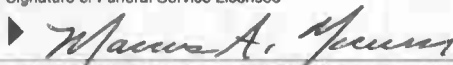
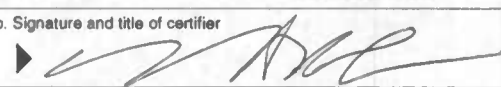

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State of Maryland / Department of Health and Mental Hygiene

00 30033

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William Wilson Brimer</b>				2. Date of Death Month <b>Sept.</b> Day <b>2,</b> Year <b>2000</b>		3. Time of Death <b>4:25</b>		
	4a. Facility Name (If not institution, give street and number) <b>SALISBURY CENTER: GENESIS ELDERCARE</b>				4b. City, Town, or Location of Death <b>SALISBURY, MD</b>		4c. County of Death <b>WICOMICO</b>		
Funeral Director	5. Social Security Number <b>216-12-1463</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>5-13-1910</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>	
	Usual Residence of Decedent								
10a. State <b>Md.</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>200 Civic Ave.</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assemble Line worker</b>		16b. Kind of Business/Industry <b>Bakery</b>			
17. Father's Name (First, Middle, Last) <b>William Henry Brimer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Winona Griffin Brimer</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Rebecca Lee Brittingham, Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>400 Lincoln Ave. Delmar, De. 19940</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Christian Cemetery</b>		Date <b>9-5-00</b>		20c. Location - City or Town, State <b>Snow Hill, Md.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
Immediate Cause (Final disease or condition resulting in death)		a. <b>Pulmonary Fibrosis</b> Due to (or as a consequence of): <b>years.</b>					Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Coronary artery Disease</b> Due to (or as a consequence of): <b>years</b>							
		c. Due to (or as a consequence of):							
		d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>028349</b>		29d. Date signed (Month, Day, Year) <b>9/5/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Alex Jerome 1104 HEALTHWAY DR., SALISBURY, MD 21804</b>									
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 							

ORIGINAL



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Amend Item 26, per Phy.

State of Maryland / Department of Health and Mental Hygiene

00 30034

09/08/2000, Carroll County, wjl

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nora Winkler Barnard		2. Date of Death Month Day Year 09 05 2000		3. Time of Death 5:25pm	
	4e. Facility Name (If not institution, give street and number) Golden Age Guest Home		4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 214-46-7700	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 97	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug 27, 1903
	9. Birthplace (State or Foreign Country) TN					
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Md		10b. County Howard	
	10c. City, Town or Location Mt. Airy		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1075 St. Michael Rd		10f. Zip Code 21771		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: white		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker	
	16b. Kind of Business/Industry domestic		17. Father's Name (First, Middle, Last) Henley Winkler		18. Mother's Name (First, Middle, Maiden Surname) Nervie Sutton	
	19a. Informant's Name/Relationship (Type, Print) Dayton Barnard (son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1075 St. Michael Rd., Mt. Airy, MD 21771			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Barnard-Winkler Cem.		20c. Location - City or Town, State 9-11-2000 Sneedville, TN	
	21. Signature of Funeral Service Licensee ► Paige Haight Herbert		22. Name and Address of Facility Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md 21784			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. PRIMARY DEGENERATIVE DEMENTIA Due to (or as a consequence of): b. CEREBROVASCULAR DISEASE Due to (or as a consequence of): c. DIABETES MELLITUS, TYPE II Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death > 2 YRS > 2 YRS > 2 YRS					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE HYPERTENSION		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) (Hospice)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier ► Patrick Turnes		29c. License number D20806		
29d. Date signed (Month, Day, Year) 09/05/2000						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DR. Patrick Turnes 1425 Liberty Rd. Suite 209 Eldersburg, MD 21784						
31. Date filed (Month, Day, Year) SEP 08 2000		32. Registrar's Signature ► [Signature] B Sparks				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

00 30035

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Nancy Lee Bennett				2. Date of Death Month: Sept Day: 5 Year: 2000		3. Time of Death 5:25pm	
	4a. Facility Name (If not institution, give street and number) 3515 Ellen Drive				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 219-26-9770		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 21, 1939	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3515 Ellen Dr.		10f. Zip Code 21157		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (14 or 5+): none		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Supervisor of Inventory		16b. Kind of Business/Industry UMBC / Education			
	17. Father's Name (First, Middle, Last) Lawrence Leight				18. Mother's Name (First, Middle, Maiden Surname) Myrtle Elizabeth Kraft			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) George Bennett/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3515 Ellen Dr. Westminster, MD 21157			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Ridge Cemetery		20c. Location - City or Town, State Elkridge, MD		20d. Date 09/08/00	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Melanoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 12 years
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier MD				29c. License number 038409		29d. Date signed (Month, Day, Year) 9/6/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM SHUFFIN JOHN HOPKINS AT GREENSPARK STATION, 10753 FINE RD, #415, MONTGOMERY, MD 21093							
State Registrar	31. Date filed (Month, Day, Year) SEP 07 2000				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30036

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Palmer Bull				2. Date of Death Month Day Year Sept. 07, 2000		3. Time of Death 5:55 A.M.	
	4a. Facility Name (If not institution, give street and number) Fairhaven Nursing Home				4b. City, Town, or Location of Death Sykesville		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 214-38-4275	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 3, 1911	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County Carroll	10c. City, Town or Location Sykesville			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 7200 Third Ave.			10f. Zip Code 21784		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Librarian		16b. Kind of Business/Industry Education			
	17. Father's Name (First, Middle, Last) M. Herbert Palmer				18. Mother's Name (First, Middle, Maiden Surname) Helen Groten Taylor			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) James Bull / Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 540 Elm St. #13 San Carlos, CA 94070			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation Inc.		Date 9/8/00		20c. Location - City or Town, State Hampstead, MD	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 412 Washington Rd. Westminster, MD 21157					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease 10 yrs Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
State Registrar	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 			29c. License number D32882		29d. Date signed (Month, Day, Year) 9/7/00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Moss 114 Business Center Drive Reisterstown, MD							
31. Date filed (Month, Day, Year) SEP 07 2000		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30037

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ivan R. Barnes

2. Date of Death

Month Day Year  
September 2, 2000

3. Time of Death

6:15 PM

4a. Facility Name (If not institution, give street and number)

Keswick Multi-Care Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

220-01-2043

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 6, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

278 Winterberry Lane

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Building Inspector

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

James A. Barnes

18. Mother's Name (First, Middle, Maiden Surname)

Eunice Reeves

19a. Informant's Name/Relationship (Type, Print)

Gary Barnes, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

278 Winterberry Lane, Westminster, MD 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Carroll Cremations

Date

9/7

20c. Location - City or Town, State

Hampstead, Md

21. Signature of Funeral Service Licensee

M09723

22. Name and Address of Facility

Eline Funeral Home

934 South Main St, Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Squamous cell lung cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 month

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, unspecified

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. Isabelle MacGregor

29c. License number

D13657

29d. Date signed (Month, Day, Year)

September 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ISABELLE MACGREGOR, KESWICK, 700 W 40th STREET, BALTIMORE, MARYLAND 21211

31. Date filed (Month, Day, Year)

SEP 08 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30038

amend item 23a per phys. G787 9/22/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSE DELORES BARBER</b>				2. Date of Death Month Day Year <b>Aug. 14 2000</b>		3. Time of Death <b>10:10 AM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>730 N. Surf RD</b>				4b. City, Town, or Location of Death <b>Ocean City</b>		4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>179-16-4140</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11/5/1914</b>		
	9. Birthplace (State or Foreign Country) <b>PA</b>		10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean City</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>730 N. Surf RD</b>		10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Anthony Renkiewicz</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Amelia Puza</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Kelly Fox/ Granddaughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>502 S. Surf RD Ocean City, MD 21842</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fairview Memorial Park</b>		Date <b>8/18/00</b>		20c. Location - City or Town, State <b>Elmhurst, PA</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>The Burbage Funeral Home</b> <b>108 William St. Berlin, MD 21811</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Liver Failure SECONDARY TO CIRRHOSIS</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		23c. Approximate Interval Between Onset and Death <b>10 years</b>					
23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>11:00 AM</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i> <b>Kimberly M. Gallagher MD</b>		29c. License number <b>C10005489- DE</b>		29d. Date signed (Month, Day, Year) <b>8/14/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kimberly M. Gallagher, MD RT 1 Box 25 Ocean View, DE 19970</b>		31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

amend item 23a per phys. G787 9.22.00. yf

00 30039

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lillian Mae Bowes</b>			2. Date of Death Month <b>August</b> Day <b>26</b> Year <b>2000</b>			3. Time of Death <b>1025AM</b>				
	4a. Facility Name (If not institution, give street and number) <b>Union Hospital</b>			4b. City, Town, or Location of Death <b>Elkton</b>			4c. County of Death <b>Cecil</b>				
Funeral Director	5. Social Security Number <b>166-07-7920</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 6, 1914</b>		9. Birthplace (State or Foreign Country) <b>Pa.</b>		
	10a. State <b>Md.</b>			10b. County <b>Cecil</b>			10c. City, Town or Location <b>Elkton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>#8 2nd Street</b>			10f. Zip Code <b>21921</b>			10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>At home</b>					
17. Father's Name (First, Middle, Last) <b>Guliford Kurtz</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Beatrice Simpson</b>								
19a. Informant's Name/Relationship (Type, Print) <b>Theresa A. Bowes, Daughter-in-Law</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#9 Shawn Drive, Elkton, Md. 21921</b>								
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R. A. Ferris &amp; Co.</b>			20c. Location - City or Town, State <b>West Chester, Pa.</b>			20d. Date <b>8/28/00</b>		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>259 E. Main St., Gee Funeral Home Elkton, Md. 21921</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. Cardiac Arrest</b> Due to (or as a consequence of): <b>c. ASCVD</b> Due to (or as a consequence of): <b>d.</b>			Approximate Interval Between Onset and Death								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury <b>M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred								
28f. Location (Street and Number or Rural Route Number, City or Town, State)			28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 								
29c. License number <b>D-52087</b>			29d. Date signed (Month, Day, Year) <b>August 26, 2000</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael J. Picavilli, Jr.</b> <b>Elkton, Maryland</b>			31. Date filed (Month, Day, Year) <b>AUG 30 2000</b>								
32. Registrar's Signature 			33. Registrar's Name <b>B. Sparks</b>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30040

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Conner</b>		2. Date of Death Month Day Year <b>September 12 2000</b>		3. Time of Death <b>0205</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>182-30-1326</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>March 8, 1919</b>		9. Birthplace (State or Foreign Country) <b>VA</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Fruitland</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>427 Cartwright Avenue</b>			10f. Zip Code <b>21826</b>		10g. Citizen of What Country? <b>U.S.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Brick Mason</b>		16b. Kind of Business/Industry <b>Construction</b>	
17. Father's Name (First, Middle, Last) <b>Cornelius Conner</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Elizabeth Knox</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Helen Conner/wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>427 Cartwright Ave., Fruitland, MD 21826</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Acres Memorial Park</b>		20c. Location - City or Town, State <b>Salisbury, MD 21801</b>	
21. Signature of Funeral Director 		22. Name and Address of Facility <b>Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>BRAIN ANOXIA</b>		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>ACUTE MYOCARDIAL INFARCTION</b>		Due to (or as a consequence of):	
		c. <b>CORONARY ARTERY DISEASE</b>		Due to (or as a consequence of):	
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>D0036576</b>		29d. Date signed (Month, Day, Year) <b>9/1/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RONALD P. TRAVITZ MD 560 RIVERSIDE DR, SALISBURY MD</b>					
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature 			

From the ...  
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30041

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ARCHIE PURNELL COLONA				2. Date of Death Month Day Year September 3, 2000		3. Time of Death 1700	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 215-12-6769	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	8. Under 1 Year Months Days	9. Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) February 24, 1921		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10e. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 118 Jerome Drive				10f. Zip Code 21804		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter		16b. Kind of Business/Industry Construction			
	17. Father's Name (First, Middle, Last) John E Colona				18. Mother's Name (First, Middle, Maiden Surname) Maggie Ward			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Candace Powell/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1118 Riden Court, Salisbury, MD 21804			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parsons Cemetery		Data 9/7/00		20c. Location - City or Town, State Salisbury, MD	
	21. Signature of Funeral Service Licensee W.R. Hallenbeck CFSP				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 24 hr.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Mitral Valve Disease - Regurgitation Renal Insufficiency COPD							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier J. Steve Julian MD				29c. License number
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Steve Julian MD 201 Pine Bluff Rd Salisbury MD 21801				31. Date filed (Month, Day, Year) SEP 06 2000				32. Registrar's Signature B. Sparks

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #29c, 09/01/2000, WCHD, HLC Certificate of Death

Reg. No.

00 30042

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHIRLEY ANN COLLINS			2. Date of Death Month Day Year August 30, 2000		3. Time of Death 10:35 PM		
	4a. Facility Name (If not institution, give street and number) 27348 Independence Lane			4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 220-32-9667	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 21, 1936	9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 6120 Strawberry Way			10f. Zip Code 21801		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Repair Service Coordinator		16b. Kind of Business/Industry Telephone Co.	
	17. Father's Name (First, Middle, Last) Etheridge E. Smith			18. Mother's Name (First, Middle, Maiden Surname) Georgianna Maddox				
	19a. Informant's Name/Relationship (Type, Print) Thomas H. Collins/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6120 Strawberry Way, Salisbury, MD 21801				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens		Date 9/2/00	20c. Location - City or Town, State Hebron, MD		
	21. Signature of Funeral Service Licensee J. Holloway			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. metastatic Colon Ca Due to (or as a consequence of):							4 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):								
c. Due to (or as a consequence of):								
d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Joseph A. Grasso						
		29c. License number D20507		29d. Date signed (Month, Day, Year) 9/1/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph A. Grasso 145 E. Carrow St Salisbury MD								
31. Date filed (Month, Day, Year) SEP 01 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Continued

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30043

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY

HARTNESS

CHRISTENSEN

2. Date of Death

September 6 2000

3. Time of Death

1718

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

215-38-1440

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

September 30, 1913

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Greenbank

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medicine

17. Father's Name (First, Middle, Last)

William Alvin Hartness

18. Mother's Name (First, Middle, Maiden Surname)

Ida Neal White

19a. Informant's Name/Relationship (Type, Print)

Nancy C. Langrehr/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

88 N. Boone Rd., St. Helena Island, SC 29920

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Park

Date

9/9/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

*J. H. Holloway*

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. *Cerebral aneurysm hemorrhage involving left middle + anterior artery 3 days*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*James L. Clifford MD*

29c. License number

D 0001969

29d. Date signed (Month, Day, Year)

9/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES L. CLIFFORD MD 106 PINE BLUFF Rd Suite 12 Salisbury, MD 21801

31. Date filed (Month, Day, Year)

SEP 08 2000

32. Registrar's Signature

*B. Sparks*State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

215-38-1440

Mary Christensen



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State of Maryland / Department of Health and Mental Hygiene

00 30044

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) TERRON LAMONT CRUMP JR				2. Date of Death Month Day Year September 10 2000		3. Time of Death 0940
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number n/a	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 10, 2000	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 1004 Powhattan Blvd			10f. Zip Code 21801		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n/a		16b. Kind of Business/Industry n/a		
	17. Father's Name (First, Middle, Last) Terron Lamont Crump Sr.				18. Mother's Name (First, Middle, Maiden Surname) Sharmaine Yvette Preston		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sharmaine Y. Preston/Mother			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Powhattan Blvd., Salisbury, MD 21801			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 9/12/00	20c. Location - City or Town, State Salisbury, MD	
	21. Signature of Funeral Service Licensee David H. Thompson		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. PREMATURITY, CHORIOAMNIONITIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier Byron Jennings, M.D.			29c. License number D41515		29d. Date signed (Month, Day, Year) September 11, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Byron Jennings, M.D. 223 Philip Morris Dr. Salisbury, MD							
31. Date filed (Month, Day, Year) SEP 13 2000			32. Registrar's Signature G. Sparks				

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30045

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLARA MARGARET SHOCKLEY DESHIELDS</b>		2. Date of Death Month Day Year <b>August 31 2000</b>		3. Time of Death <b>1046</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>217-28-3462</b>	8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	6. Date of Birth (Month, Day, Year) <b>JUNE 18, 1925</b>		9. Birthplace (State or Foreign Country) <b>SNOWHILL, MD.</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD.</b>	10b. County <b>WORCESTER</b>	10c. City, Town or Location <b>SNOWHILL</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>6546 MT. OLIVE ROAD</b>		10f. Zip Code <b>21863</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>AFRO-AMERICAN</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>		16b. Kind of Business/Industry <b>HOUSEKEEPER</b>
	17. Father's Name (First, Middle, Last) <b>HOWARD SHOCKLEY</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARCIE HOLLAND</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>OSCAR SHOCKLEY/SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6550 MT. OLIVE ROAD., SNOWHILL, MD. 21863</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HUTT'S MEM. UNITED METH. CEME.</b>		20c. Location - City or Town, State <b>SNOWHILL, MD.</b>
	21. Signature of Funeral Service Licensee <i>Loretta B. Gally</i>		22. Name and Address of Facility <b>JOLLEY MEMORIAL CHAPEL</b> <b>1213 JERSEY ROAD., SALISBURY, MD. 21801</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. Circulatory collapse</b> Due to (or as a consequence of):					<b>2 days</b>
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Sepsis</b> Due to (or as a consequence of):					
<b>c.</b> Due to (or as a consequence of):					
<b>d.</b> Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Robert A. Wicks Physician</i>		29c. License number <b>56197</b>		29d. Date signed (Month, Day, Year) <b>8/31/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peninsula Regional Medical Center Salisbury MD / Robert Coker, M.D.</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL





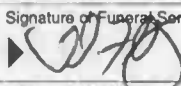

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State of Maryland / Department of Health and Mental Hygiene

00 30046

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD JACOB FROCK, SR.</b>		2. Date of Death Month Day Year <b>SEPT. 5, 2000</b>		3. Time of Death <b>8:02 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>CARROLL COUNTY GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>WESTMINSTER</b>		4c. County of Death <b>CARROLL</b>
Funeral Director	5. Social Security Number <b>216-10-6521</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>3/4/1915</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
Usual Residence of Decedent					
10a. State <b>MD.</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>CLAIBORNE</b>	
10e. Street and Number <b>10462 RICHNECK RD.</b>		10f. Zip Code <b>21624</b>		10g. Citizen of What Country? <b>USA.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LEADMAN</b>	
16b. Kind of Business/Industry <b>MANUFACTURING</b>		17. Father's Name (First, Middle, Last) <b>HARRY FROCK</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>CORA KRETZER</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Timothy E. Frock - SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10462 RICHNECK RD., CLAIBORNE, MD. 21624</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVERGREEN MEM. GARDENS</b>		20c. Location - City or Town, State <b>9/8/00 FINKSBURG, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Coronary Artery Disease</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>11 days</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Robert J. Mason, MD</b>		29c. License number <b>D32802</b>	
29d. Date signed (Month, Day, Year) <b>9/5/2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Robert Mason 114 Business Center Dr. Reisterstown, MD 21136</b>			
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 07 2000</b>		32. Registrar's Signature 		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30047

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Reno Wesley Grabill				2. Date of Death Month Day Year September 4 2000		3. Time of Death 8:35PM	
	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Home				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 213-36-7672		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 29, 1918	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Union Bridge			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 12731 Molasses Rd.				10f. Zip Code 21791		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) farmer		16b. Kind of Business/Industry dairy		
17. Father's Name (First, Middle, Last) A. Webster Grabill				18. Mother's Name (First, Middle, Maiden Surname) Utie Idella Beard				
19a. Informant's Name/Relationship (Type, Print) Mary A. Grabill/ wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12731 Molasses Rd. Union Bridge, MD 21791				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Hill Cemetery		Date 9/7/00		20c. Location - City or Town, State nr. Woodsboro, MD
21. Signature of Funeral Service Licensee <i>Catherine O. Hartzler</i>				22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Sepsis</i> Due to (or as a consequence of):  b. <i>urinary tract infection</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <i>Days.</i>  <i>Days.</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>advanced dementia</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number D26499		29d. Date signed (Month, Day, Year) 9-6-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller 4 Culwell Dr. Mt. Airy, MD 21771								
31. Date filed (Month, Day, Year) SEP 08 2000				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 26, per Phy.

State of Maryland / Department of Health and Mental Hygiene

09/07/2000, Carroll County, wjl

## Certificate of Death

Reg. No.

00 30048

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Linwood H. Greenwalt				2. Date of Death Month: Sept. Day: 5 Year: 2000				3. Time of Death 11:30 PM	
	4e. Facility Name (If not institution, give street and number) 4440 Hay Drive				4b. City, Town, or Location of Death Manchester				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 218-18-4908		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 28, 1917		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Florida		10b. County St. Lucie		10c. City, Town or Location Jensen Beach	
To Be Completed by Funeral Director	10e. Street and Number 313 Nettles Blvd.				10f. Zip Code 34957		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) 12th				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner Greenwalt Paving Co.				16b. Kind of Business/Industry Construction	
	17. Father's Name (First, Middle, Last) Harry Greenwalt				18. Mother's Name (First, Middle, Maiden Surname) Catherine Cullum					
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) Blanche A. Greenwalt Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Nettles Blvd. Jensen Beach, FL 34957					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial Park 9/8/2000 Finksburg, MD				20c. Location - City or Town, State	
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee James B. Conroy				22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Sepsis with Septic Shock 10 days Due to (or as a consequence of): b. Aspiration pneumonia 10 days Due to (or as a consequence of): c. Atherosclerotic cardiovascular disease 2 years Due to (or as a consequence of): d. disease				Approximate Interval Between Onset and Death					
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Son's Residence					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Khalil Freij MD				29c. License number D38915	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) 9/16/2000				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) KHALIL FREIJ 295 Stoner Ave Westminster, MD					
	31. Date filed (Month, Day, Year) SEP 07 2000				32. Registrar's Signature B. Sparks				21157	

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30049

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Sterling Greenwood				2. Date of Death Month Day Year Sept 7, 2000		3. Time of Death 1:17 am	
	4a. Facility Name (If not institution, give street and number) 4518 Maple Grove Road				4b. City, Town, or Location of Death Hampstead		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 213-12-7455		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) Aug 5, 1921	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Carroll		10c. City, Town or Location Hampstead	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 4518 Maple Grove Road		10f. Zip Code 21074		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Driver		16b. Kind of Business/Industry Westinghouse		17. Father's Name (First, Middle, Last) Sterling Greenwood	
	18. Mother's Name (First, Middle, Maiden Surname) Margaret Coppersmith		19a. Informant's Name/Relationship (Type, Print) Trula Greenwood, wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4518 Maple Grove Rd, Hampstead, MD 21074		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Memorial Gard		Date 9/9		20c. Location - City or Town, State Finksburg, MD		21. Signature of Funeral Service Licensee M00723 Steven W. Elmer	
	22. Name and Address of Facility Eline Funeral Home 934 South Main St, Hampstead, MD 21074		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction Due to (or as a consequence of): Severe coronary artery disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Atrial fibrillation Moderate aortic stenosis Severe COPD		Approximate interval Between Onset and Death hours		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) M		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier D. D. Salama MD		29c. License number D 23015		29d. Date signed (Month, Day, Year) 9/7/2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 217 Washington Heights Westminister Md 21157 DINESH KALARIA, M.D.	
State Registrar	31. Date filed (Month, Day, Year) SEP 08 2000		32. Registrar's Signature D. D. Salama		33. Date of Death SEP 07 2000		34. Time of Death 1:17 am	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30050

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Imogene M. Holman

2. Date of Death

Month Day Year  
Sept. 16 2000

3. Time of Death

8:45 AM

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

227-42-9498

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 28, 1933

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15019 Redgate Drive

10f. Zip Code

20905

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
216. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supply Expediter

16b. Kind of Business/Industry

US Navy

17. Father's Name (First, Middle, Last)

Robert Riley Jackson Mitchell

18. Mother's Name (First, Middle, Maiden Surname)

Nina Tibbs

19a. Informant's Name/Relationship (Type, Print)

Herbert Holman/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15019 Redgate Drive, Silver Spring, MD 20905

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Union Cemetery

Date

9/19/00

20c. Location - City or Town, State

Burtonsville, MD

21. Signature of Funeral Service Licensee

*Shirley D. Sanchez* MOO160

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue, Laurel, Maryland, 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Metastatic lung cancer*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

76 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic obstructive Pulmonary Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Pending  
Investigation  
3 ☐ Accident 4 ☐ Suicide  
5 ☐ Could not be  
determined  
6 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*Rahul Gilotra*

29c. License number

D 32417

29d. Date signed (Month, Day, Year)

September 16<sup>th</sup>, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAHUL GILOTRA M.D. 12016 GEORGIA AVE Wheaton MD 20902

31. Date filed (Month, Day, Year)

SEP 19 2000

32. Registrar's Signature

*B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30051

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RONALD G. HOOD</b>				2. Date of Death Month <b>Sept</b> Day <b>16</b> Year <b>2000</b>		3. Time of Death <b>12:37AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>		
Funeral Director	5. Social Security Number <b>213 30 5724</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 26, 1933</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Elkridge</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6645 Deep Run Parkway</b>		10f. Zip Code <b>21075</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Pressman</b>		16b. Kind of Business/Industry <b>Baltimore County Govt.</b>					
17. Father's Name (First, Middle, Last) <b>James Hood</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Rebhan</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Lennox G. Hood/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9334 Our Time Lane Columbia, Maryland 21045</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>9-20-2000 Catonsville, MD</b>					
21. Signature of Funeral Service Licensee <b>Shen a Collins-Wright</b>		22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Atherosclerotic Cardiovascular Disease</b>		Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):							
		Due to (or as a consequence of):							
		Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Hypercholesterolemia, Diabetes, &amp; P CABG</b>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Michael Quigley MD</b>		29c. License number <b>00057958</b>		29d. Date signed (Month, Day, Year) <b>September 17, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Quigley MD</b>									
31. Date filed (Month, Day, Year) <b>SEP 18 2000</b>		32. Registrar's Signature <b>James B. Sparks</b>							





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30052

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nora B. Hammer</b>				2. Date of Death Month <b>Sept.</b> Day <b>12</b> Year <b>2000</b>		3. Time of Death <b>1:50 pm</b>																
	4a. Facility Name (If not institution, give street and number) <b>Hillside House 5502 Harris Farm Rd.</b>				4b. City, Town, or Location of Death <b>Clarksville</b>		4c. County of Death <b>Howard</b>																
Funeral Director	5. Social Security Number <b>267-41-0567</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>99</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr. 27, 1901</b>	9. Birthplace (State or Foreign Country) <b>Texas</b>																
	Usual Residence of Decedent																						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Howard</b>	10c. City, Town or Location <b>Ellicott City</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
	10e. Street and Number <b>3629 Cragmoor Rd.</b>			10f. Zip Code <b>21042</b>		10g. Citizen of What Country? <b>United States</b>																	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>																
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>																	
	17. Father's Name (First, Middle, Last) <b>William R. Biddle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mattie I. Fagala</b>																		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>R. James Hammer / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3629 Cragmoor Rd. Ellicott City, MD. 21042</b>																		
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Memorial Park Cemetery</b>		Date <b>Sept. 18 2000</b>	20c. Location - City or Town, State <b>St. Petersburg, Fla.</b>																	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043</b>																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Arrhythmia</b></td> <td>Approximate Interval Between Onset and Death <b>5 years</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>Congestive Heart Failure</b></td> <td><b>5 years</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. <b>Humerus Fracture</b></td> <td><b>1 week</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d. <b>Atrial Fibrillation</b></td> <td><b>5 years</b></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>Arrhythmia</b>	Approximate Interval Between Onset and Death <b>5 years</b>	Due to (or as a consequence of):		b. <b>Congestive Heart Failure</b>	<b>5 years</b>	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <b>Humerus Fracture</b>	<b>1 week</b>	Due to (or as a consequence of):		d. <b>Atrial Fibrillation</b>
Immediate Cause (Final disease or condition resulting in death)	a. <b>Arrhythmia</b>	Approximate Interval Between Onset and Death <b>5 years</b>																					
	Due to (or as a consequence of):																						
	b. <b>Congestive Heart Failure</b>	<b>5 years</b>																					
	Due to (or as a consequence of):																						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. <b>Humerus Fracture</b>	<b>1 week</b>																					
	Due to (or as a consequence of):																						
	d. <b>Atrial Fibrillation</b>	<b>5 years</b>																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Asst. Lving.</b>																				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred																	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																						
	29b. Signature and title of certifier <b>Rita E. King M.D.</b>				29c. License number <b>D0037155</b>		29d. Date signed (Month, Day, Year) <b>September 13, 2000</b>																
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Rita E. King 11085 Little Patuxent Pkwy. Columbia, MD. 21044</b>																							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 14 2000</b>		32. Registrar's Signature 																				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30053

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Dolores Hauser

2. Date of Death

Month Day Year  
Sept. 14 2000

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

16109 Malcolm Drive

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

219-42-3898

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 5, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

16109 Malcolm Drive

10f. Zip Code

20707

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Analyst

16b. Kind of Business/Industry

C.I.A.

17. Father's Name (First, Middle, Last)

Alfred LePore

18. Mother's Name (First, Middle, Maiden Surname)

Anna Elder

19a. Informant's Name/Relationship (Type, Print)

John Hauser/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16109 Malcolm Drive, Laurel, Maryland, 20707

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

9/14/00

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

G. S. K. MOO770

22. Name and Address of Facility

Donaldson Funeral Home, P.A.  
313 Talbott Avenue, Laurel, Maryland, 2070723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Melanoma Metastatic to Lung, Liver, Brain, Lymphnode

Approximate  
Interval Between  
Onset and Death

1 Year

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Anemia

SIP Chemotherapy, SIP Radiation Therapy

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural  
☐ Accident  
☐ Suicide  
☐ Homicide☐ Pending  
investigation  
☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. K. Minford

29c. License number

D30573

29d. Date signed (Month, Day, Year)

9-14-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Minford, 2 Knoll North, Columbia, Maryland, 21045

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

Benedict G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30054

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILSON E HEARN				2. Date of Death Month: September Day: 10 Year: 2000		3. Time of Death 0828
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 218-05-8717	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) April 26, 1919	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Fruitland		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 107 S. Dulaney Ave.				10f. Zip Code 21826		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 0 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Messick's Ice Plant			
17. Father's Name (First, Middle, Last) George W. Hearn				18. Mother's Name (First, Middle, Maiden Surname) Clara Maria Jones			
19a. Informant's Name/Relationship (Type, Print) William T. Hearn/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 107 S. Dulaney Ave., Fruitland, MD 21826			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 9/11/00		20c. Location - City or Town, State Salisbury, MD	
21. Signature of Funeral Service Licensee <i>David A. Thompson</i>		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>metastatic Prostate Cancer</i> Due to (or as a consequence of): b. <i>chronic obstructive pulmonary disease</i> Due to (or as a consequence of): c. <i>Anemia</i> Due to (or as a consequence of): d. <i>Acute Myeloid Leukemia</i>							Approximate Interval Between Onset and Death a. <i>&lt; 1 yr</i> b. <i>10 yrs</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>David A. Thompson, M.D.</i>		29c. License number B334123193		29d. Date signed (Month, Day, Year) 9/10/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1201 Peninsula Bridge Dr. Salisbury MD 21804							
31. Date filed (Month, Day, Year) SEP 13 2000		32. Registrar's Signature <i>P. Sparks</i>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30055

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANNIE MAE JOHNSON</b>				2. Date of Death Month: <b>SEPT.</b> Day: <b>8</b> Year: <b>2000</b>		3. Time of Death <b>2:32 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>11625 CHURCH STREET</b>				4b. City, Town, or Location of Death <b>SHOWELL</b>		4c. County of Death <b>WORCESTER</b>		
Funeral Director	5. Social Security Number <b>219-36-5021</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>59 Yrs.</b>	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>SEPT. 5, 1941</b>	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
10a. State <b>MARYLAND</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>SHOWELL</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>11625 CHURCH STREET</b>				10f. Zip Code <b>21862</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>12</b> College (1-4 or 5+):				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>			16b. Kind of Business/Industry <b>OWN HOME</b>		
17. Father's Name (First, Middle, Last) <b>PAUL JONES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ALBERTA STEWART</b>					
19a. Informant's Name/Relationship (Type, Print) <b>BRIAN K. JOHNSON/ SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 23, SHOWELL, MARYLAND 21862</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SPRINGHILL MEM. GARDENS</b>		Date <b>9/12/00</b>		20c. Location - City or Town, State <b>SALISBURY, MARYLAND</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung Cancer</b> Due to (or as a consequence of): <b>b. Metastatic Cancer Brain</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 		29c. License number <b>H51718</b>		29d. Date signed (Month, Day, Year) <b>9/11/00</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>10514 Redbank Rd Unit C Berlin MD, 21111</b>									
31. Date filed (Month, Day, Year) <b>SEP 13 2000</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30056

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

UREE MCDONALD JOHNSON

2. Date of Death  
Month Day Year

Sept. 9, 2000

3. Time of Death

11:24 AM

4a. Facility Name (If not institution, give street and number)

Look About Manor Nursing Home

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

215-48-2843

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Jan. 25, 1911

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1510 Stone Road

10f. Zip Code

21157

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

James Edward Smith

18. Mother's Name (First, Middle, Maiden Summa)

Uree Frances McDonald

19a. Informant's Name/Relationship (Type, Print)

Friedrich Maier/friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10604 Lester Street, Silver Spring, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

9/14

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Robert A. Hyman

22. Name and Address of Facility

Myers Funeral Home  
91 Willis Street  
Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SKIN ULCER  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CVA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)29b. Signature and title of certifier  
Philip J. Ruzbarsky MD  
29c. License number  
D 33599  
29d. Date signed (Month, Day, Year)  
09-11-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Philip J. Ruzbarsky 125 Airport Drive, Westminster, MD 21157

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Uree G. Johnson  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30057

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE THOMAS LEONARD</b>				2. Date of Death Month <b>September</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>0312</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>218-16-7726</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>February 10, 1925</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Salisbury</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>400 E. Lincoln Ave</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Navy</b> If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Food Inspector</b>		16b. Kind of Business/Industry <b>U.S. Dept. Agriculture</b>		
	17. Father's Name (First, Middle, Last) <b>George William Leonard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Frances Smith</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Joe F. Leonard/Brother</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>601 E. Lincoln Ave., Salisbury, MD 21804</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>		Date <b>9/13/00</b>	20c. Location - City or Town, State <b>Salisbury, MD</b>	
	21. Signature of Funeral Service Licensee <b>David A. Thompson</b> MO1051		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Malignant lymphoma T-cell type</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>7 days</b>						
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Refranso</b>		29c. License number <b>020507</b>		29d. Date signed (Month, Day, Year) <b>9/11/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph A. Grasso 145 E. Carroll St Salisbury MD.</b>							
31. Date filed (Month, Day, Year) <b>SEP 13 2000</b>		32. Registrar's Signature <b>B. Sparks</b>					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30058

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGIE LEE LAWSON</b>			2. Date of Death Month Day Year <b>September 12, 2000</b>		3. Time of Death <b>4:20AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3831 Old Washington Road</b>			4b. City, Town, or Location of Death <b>Waldorf</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>578-22-5067</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F <b>XXX</b>	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 26, 1922</b>	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Charles</b>	10c. City, Town or Location <b>Waldorf</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>3831 OLD WASHINGTON ROAD</b>			10f. Zip Code <b>20602</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
	17. Father's Name (First, Middle, Last) <b>UNAVAILABLE</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>EVA HUMMER</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>DIXIE LEE SPADA/DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3831 OLD WASHINGTON ROAD, WALDORF, MARYLAND 20602</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEMETERY</b>		20c. Location - City or Town, State <b>09-15-2000 BRENTWOOD, MARYLAND</b>		
	21. Signature of funeral service provider <b>MARK G. BROHAWN</b>		22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Chronic Obstructive Pulmonary Disease-End Stage</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>XXX</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No						
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
	28e. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
State Registrar	29b. Signature and title of certifier <b>Paul Pritchett, MD</b>			29c. License number <b>D000 P370</b>		29d. Date signed (Month, Day, Year) <b>9/12/2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Pritchett, MD, P.O. Box 1317, La Plata, MD 20646</b>						
31. Date filed (Month, Day, Year) <b>SEP 13 2000</b>		32. Registrar's Signature <b>Gene B. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Handwritten text, possibly a signature or date, located in the center of the page.



jhm  
LORI ANN  
MCCOY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30059

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LORI ANN MCCOY				2. Date of Death Month Day Year SEPTEMBER 2, 2000				3. Time of Death 17:15 PM	
	4a. Facility Name (If not Institution, give street and number) 110 HALSEY DRIVE				4b. City, Town, or Location of Death SALISBURY				4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 213-78-1518		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) July 19, 1962		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 110 Halsey Drive				10f. Zip Code 21804	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacy Tech				16b. Kind of Business/Industry Pharmacy				17. Father's Name (First, Middle, Last) James Lee Wanex	
	18. Mother's Name (First, Middle, Maiden Surname) Carolyn Lee Taylor				19a. Informant's Name/Relationship (Type, Print) Harry R. McCoy/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Halsey Dr., Salisbury, MD 21804	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory				20c. Location - City or Town, State 9/5/00 Salisbury, MD	
	21. Signature of Funeral Service Licensee Keith R. Droney				22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804				23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Strangulation and Blunt Force Injuries Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE				27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) 9/2/00				28b. Time of Injury UNK M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28d. Describe how Injury occurred Subject strangled and beaten				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME				28f. Location (Street and Number or Rural Route Number, City or Town, State) 110 Halsey Drive 21804		
Physician /Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier J. Canon Locke MD				29c. License number OCME	
	29d. Date signed (Month, Day, Year) SEPTEMBER 03, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Canon Locke MD				31. Date filed (Month, Day, Year) SEP 06 2000	
	32. Registrar's Signature S. Sparks				33. Registrar's Signature S. Sparks				34. Registrar's Signature S. Sparks	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,






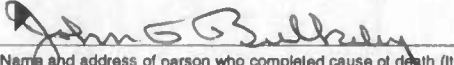

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30060

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MILTON W MATHEWS</b>		2. Date of Death Month Day Year <b>September 3, 2000</b>		3. Time of Death <b>0627</b>
	4a. Facility Name (If not Institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>217-58-6501</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>March 9, 1951</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>
	10c. City, Town or Location <b>Mardela Springs</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>24190 Main Street</b>		10f. Zip Code <b>21837</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>-</b>		16. Kind of Business/Industry <b>Retail Furniture</b>
	17. Father's Name (First, Middle, Last) <b>Isadore Carr Mathews</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Marie Wright</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Debbi Mathews/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24190 Main St., Mardela Springs, MD 21837</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>		
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  <b>J. T. Bulkeley</b>		29c. License number <b>D0003599</b>	
29d. Date signed (Month, Day, Year) <b>9-3-00</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOHN T. BULKELEY, MD 106 MILFORD ST SALISBURY, MARYLAND 21804</b>			
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30061

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANNA MOROLO</b>				2. Date of Death Month Day Year <b>SEP 05 2000</b>				3. Time of Death <b>1020</b>	
	4a. Facility Name (If not institution, give street and number) <b>Howard County General Hospital</b>				4b. City, Town, or Location of Death <b>Columbia</b>				4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>171-03-6754</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <b>Jan 28 1919</b>	
	9. Birthplace (State or Foreign Country) <b>PA</b>		Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Taneytown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>4521 Babylon Road</b>				10f. Zip Code <b>21787</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>				17. Father's Name (First, Middle, Last) <b>Michael Haslego</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Buda</b>				19a. Informant's Name/Relationship (Type, Print) <b>Toni Kozera/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4521 Babylon Road Taneytown, MD 21787</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cem</b>				20c. Location - City or Town, State <b>9/8 Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>John K. Arley</b>				22. Name and Address of Facility <b>Pritts Funeral Home and Chapel</b> <b>412 Washington Rd Westminster, MD 21157</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CORONARY ARTERY DISEASE</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHF, Diabetes mellitus II</b>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
Physician /Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Pritam S. Saini MD</b>				29c. License number <b>D28998</b>	
	29d. Date signed (Month, Day, Year) <b>SEP 6, 00</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PRITAM S SAINI MD</b> <b>9101 CHERRY LANE, SUITE 211, LAUREL MD 20708</b>				31. Data filed (Month, Day, Year) <b>SEP 07 2000</b>	
	32. Registrar's Signature <b>Benita B Sparks</b>				33. State Registrar <b>SEP 07 2000</b>				34. State Registrar	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30062

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Charles McCoy

2. Date of Death

Month  
SeptDay  
11Year  
2000

3. Time of Death

3:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

5. Social Security Number

216-14-0194

6. Sex

☒ M ☐ F

7. Age (in yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
April 30, 1913

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

466 Dutchmans Lane

10f. Zip Code

21639

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 43-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

mechanic

16b. Kind of Business/Industry

automobile

17. Father's Name (First, Middle, Last)

William C. McCoy

18. Mother's Name (First, Middle, Maiden Summa)

Clara Clark McCoy

19a. Informant's Name/Relationship (Type, Print)

Winifred R. McCoy/ wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

466 Dutchmans Lane Greensboro, MD 21639

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Glen Haven Cemetery

Date

9/13

20c. Location - City or Town, State

Glen Bernie, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleagle & Helfenbein Funeral Home, PA  
P.O. Box 160 Greensboro, MD 2163923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Pneumonia  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D47492

29d. Date signed (Month, Day, Year)

9-11-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jeff Denton P.O. Box 122 Goldsboro MD 21636State  
Registrar

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30063

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES WINFIELD NEAL</b>				2. Date of Death Month Day Year <b>September 06, 2000</b>		3. Time of Death <b>8:35 P.M.</b>														
	4a. Facility Name (If not institution, give street and number) <b>Mercy Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>														
Funeral Director	5. Social Security Number <b>579-56-2459</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 4, 1944</b>		9. Birthplace (State or Foreign Country) <b>WASHINGTON, D.C.</b>													
	Usual Residence of Decedent																				
10a. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10c. City, Town or Location <b>LA PLATA</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
10e. Street and Number <b>P.O. BOX 1267</b>				10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>UNITED STATES</b>															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>MAINTENANCE</b>															
17. Father's Name (First, Middle, Last) <b>RICHARD WELVIN NEAL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY GRACE HARLEY NEAL PROCTOR</b>																	
19a. Informant's Name/Relationship (Type, Print) <b>BARBARA A. PROCTOR / SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7050 ANNAPOLIS WOODS ROAD, LA PLATA, MARYLAND 20646</b>																	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>RESURRECTION CEMETERY</b>		20c. Location - City or Town, State <b>9/16/00 CLINTON, MARYLAND</b>															
21. Signature of Funeral Service Licensee <i>Lidia C. Thornton Johnson</i> <b>LYDIA C. THORNTON JOHNSON M00583</b>				22. Name and Address of Facility <b>THORNTON FUNERAL HOME, P.A.</b> <b>3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640</b>																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Cardiac Arrhythmia</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>Arteriosclerotic Cardiovascular Disease</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	<b>Cardiac Arrhythmia</b>	Due to (or as a consequence of):		b.	<b>Arteriosclerotic Cardiovascular Disease</b>	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.		d.	
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Cardiac Arrhythmia</b>																			
	Due to (or as a consequence of):																				
	b.	<b>Arteriosclerotic Cardiovascular Disease</b>																			
	Due to (or as a consequence of):																				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.																				
	d.																				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown																					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, Chronic Renal Insufficiency</b>																					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred													
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier <i>Dennis Chute</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 07, 2000</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201</b>																					
31. Date filed (Month, Day, Year) <b>SEP 13 2000</b>		32. Registrar's Signature <i>B. Sparks</i>																			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30064

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Parkinson

2. Date of Death

Sept 3 2000 5AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Deer's Head Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

216-56-2023

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 1, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Deer's Head Center Road

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurses Aide

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Daniel L. Parkinson

18. Mother's Name (First, Middle, Maiden Surname)

Louise Hooper

19a. Informant's Name/Relationship (Type, Print)

Daniel L. Parkinson Jr./Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6045 Zinfandel Dr., Suwanee, GA 30024

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parsons Cemetery

Date

9/6/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

John N. Hollaway

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Pulmonary Edema

Approximate  
Interval Between  
Onset and Death

30 mins

Due to (or as a consequence of):

b. End stage Renal disease on Hemodialysis

2 yrs

Due to (or as a consequence of):

c. Chronic glomerulonephritis

7 2 yrs

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease  
Chronic smoker

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

M. Shrestha M.D.

29c. License number

D0016278

29d. Date signed (Month, Day, Year)

Sept. 3. 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SHRESTHA, MD. DEER'S HEAD CENTER P.O. Box 2018, SALISBURY, MD 21802

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

J. Sparks

- 2018

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and is  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30065

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David H. Pierce, Sr.				2. Date of Death Month: Sept Day: 01 Year: 2000		3. Time of Death 7:05 AM		
	4a. Facility Name (If not institution, give street and number) 8942 Stephen Decatur Highway				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester		
Funeral Director	5. Social Security Number 214-18-4980		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Dec 3, 1918		
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Worcester		10c. City, Town or Location Berlin		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 8942 Stephen Decatur Highway		10f. Zip Code 21811		
	10g. Citizen of What Country? U.S.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Army		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 7th College (14 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Caretaker				16b. Kind of Business/Industry Banking				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John Pierce				18. Mother's Name (First, Middle, Maiden Surname) Bertha Butler				
	19a. Informant's Name/Relationship (Type, Print) Francis Pierce/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8942 Stephen Decatur Highway, Berlin, MD 21811				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Cemetery		20c. Location - City or Town, State Berlin, MD		
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Adenocarcinoma of Stomach with metastasis to Liver Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 12 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Bill Green, MD				
To Be Completed by Physician/Medical Examiner	29c. License number D-35764				29d. Date signed (Month, Day, Year) 9/5/00				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bill Green 124 North Main Street Berlin, Md. 21811				31. Date filed (Month, Day, Year) SEP 05 2000				
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature S. Sparks				33. Date of Death (Month, Day, Year) SEP 05 2000				
	34. Date of Death (Month, Day, Year) SEP 05 2000				35. Date of Death (Month, Day, Year) SEP 05 2000				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30066

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EULALIA SYLVIA PRICE				2. Date of Death Month: September, Day: 7, Year: 2000		3. Time of Death 12:05 PM		
	4a. Facility Name (If not institution, give street and number) 313 Ferry Street				4b. City, Town, or Location of Death Sharptown		4c. County of Death Wicomico		
Funeral Director	5. Social Security Number 360-18-4970	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) January 18, 1916		9. Birthplace (State or Foreign Country) Illinois	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Sharptown			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 313 Ferry Street			10f. Zip Code 21861		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 8 College (1-4 or 5+): -		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic				
	17. Father's Name (First, Middle, Last) Sylvester Durinski				18. Mother's Name (First, Middle, Maiden Surname) Eugenia Docowski				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Joseph S. Price/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Ferry St., Sharptown, MD 21861				
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 9/8/00		20c. Location - City or Town, State Salisbury, MD		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCAD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
State Registrar	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD DME		29c. License number 00054127		29d. Date signed (Month, Day, Year) 9/7/00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alon DAVIS 3 Bistate Blvd Delmar MD 21875								
	31. Date filed (Month, Day, Year) SEP 08 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30067

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLOTTE LOWE PHILLIPS		2. Date of Death Month Day Year September 11, 2000		3. Time of Death 12:05 PM
	4a. Facility Name (If not institution, give street and number) 514 N. Pinehurst Ave.		4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico
Funeral Director	5. Social Security Number 219-07-5596	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) June 26, 1918		9. Birthplace (State or Foreign Country) Maryland		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Wicomico	10c. City, Town or Location Salisbury		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number 514 N. Pinehurst Ave.		10f. Zip Code 21801		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Domestic		
	17. Father's Name (First, Middle, Last) H. J. Lowe		18. Mother's Name (First, Middle, Maiden Surname) Isabelle Carey		
	19a. Informant's Name/Relationship (Type, Print) William H. Phillips/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Montrose Lane, Laurinburg, NC 28352		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		20c. Location - City or Town, State 9/12/00 Salisbury, MD
	21. Signature of Funeral/Service Licensee <i>[Signature]</i>		22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Adenocarcinoma of esophagus &amp; pulmonary metastasis -</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 1 yr.
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D15851		29d. Date signed (Month, Day, Year) 9/12/00
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2051. <i>[Signature]</i> Salisbury, MD 21801 John A. Routenber				
31. Date filed (Month, Day, Year) SEP 13 2000		32. <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30068

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazle Marie Patton

2. Date of Death

Month 09 Day 11 Year 2000

3. Time of Death

2:15 p.m.

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home, Inc.

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

194-22-9296

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 17, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Denton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12 Fourth Street

10f. Zip Code

21629

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Caucasian

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Factory

17. Father's Name (First, Middle, Last)

Charles Henry Todd

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Omella Breeding

19a. Informant's Name/Relationship (Type, Print)

Norma L. Willey

Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6259 Terrapin Drive, Manassas, Virginia 20112

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Denton Cemetery

Date

9/14/00

20c. Location - City or Town, State

Denton, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alzheimer's Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery diseasediabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 M.D.

29c. License number

D0047534

29d. Date signed (Month, Day, Year)

9/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wafik Zaki, M.D., 920 Market Street, Denton, Maryland 21629

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30069

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty Marie Pippin

2. Date of Death

Month Day Year  
Sept 14, 2000

3. Time of Death

6:15 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

5. Social Security Number

219-03-3262

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 18, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Greensboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

202 Cedar Lane

10f. Zip Code

21639

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Harry Jones

18. Mother's Name (First, Middle, Maiden Surname)

Lola Sipple

19a. Informant's Name/Relationship (Type, Print)

William Pippin spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 Cedar Lane Greensboro, Maryland 21639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greensboro Cemetery

Date

Sept 17  
2000

20c. Location - City or Town, State

Greensboro, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fleegle - Helfenbein Funeral Home PA

PO Box 160 Greensboro, Maryland 21639

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Congestive heart Failure

Approximate  
Interval Between  
Onset and Death

Months

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D31376

29d. Date signed (Month, Day, Year)

9-14-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sides 920 Market St Denton MD 21629

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner MUST be notified at  
900-555-1234.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30070

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HATTIE TWERSKY ROSENBERG</b>			2. Date of Death Month Day Year <b>September 1, 2000</b>		3. Time of Death <b>10:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Atria Assisted Living</b>			4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>185-36-0419</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>December 2, 1908</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1110 Healthway Drive</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Public Education</b>		
	17. Father's Name (First, Middle, Last) <b>Isaac Twersky</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Becker</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Ann R. Hancock/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1214 Orchid Circle, Salisbury, MD 21801</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Son's of Israel Cemetery</b>		Date <b>9/3/00</b>	20c. Location - City or Town, State <b>Whitehall, PA</b>	
	21. Signature of Funeral Service Licensee <b>[Signature]</b>			22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>			
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ASCVD</b> Due to (or as a consequence of): <b>b. HBP</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <b>Years</b> <b>Years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Degenerative Joint Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living Facility (Atria)</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and Title of certifier <b>[Signature]</b>		29c. License number <b>028769</b>		29d. Date signed (Month, Day, Year) <b>9/1/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NICHOLAS N. BORODULIA, MD.</b>		<b>1209 COASTAL HIGHWAY FERRYCK ISLAND, DE 19944</b>					
31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature <b>[Signature]</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30071

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN FRANCES REED

2. Date of Death

Month  
AUG.

Day

26, 2000

Year

3. Time of Death

7:30PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Salisbury Center; Genesis ElderCare

4b. City, Town, or Location of Death

Salisbury, Md.

4c. County of Death

Wicomico

5. Social Security Number

220-12-1739

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
5/14/19

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 - CIVIC AVENUE

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SHUCKED OYSTERS

16b. Kind of Business/Industry

SEAFORD OYSTER CO.

17. Father's Name (First, Middle, Last)

ROY HOLDEN

18. Mother's Name (First, Middle, Maiden Surname)

IDA MILBOURNE HONDEN

19a. Informant's Name/Relationship (Type, Print)

MARRISE DOTSON DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108-JACKSON STREET-HURLOCK MD, 21643

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARON'S CHAPEL CEMETARY

Date

9/1/2000 ROCK HALL, MD.

21. Signature of Funeral Service Licensee

Bennie Smith F/H

22. Name and Address of Facility

516-MAIN STREET-HURLOCK, MD, 21643

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

yes.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. hypertension

Due to (or as a consequence of):

yes.

c. renal insufficiency

Due to (or as a consequence of):

yes.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Sparks

29c. License number

D25349

29d. Date signed (Month, Day, Year)

9/5/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D. 1104 HEALTHWAY DRIVE, SALISBURY, MD 21804

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

LILLIAN F. REED

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30072

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HARRY EWELL RIGGIN</b>			2. Date of Death Month <b>September</b> Day <b>4</b> Year <b>2000</b>		3. Time of Death <b>1705</b>	
	4a. Facility Name (If not institution, give street and number) <b>WATERVIEW HEALTHCARE CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>215-38-1029</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>September 7, 1914</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
10e. Street and Number <b>1110 Riverside Drive</b>			10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dentist</b>		16b. Kind of Business/Industry <b>Dentistry</b>		
17. Father's Name (First, Middle, Last) <b>Harry Wesley Riggins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Ewell</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Linda R. Kenney/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1110 Riverside Dr., Salisbury, MD 21801</b>			
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		Date <b>9/6/00</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>	
21. Signature of Funeral Service Licensee <b>Keith R. Downey</b>				22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>48 Hrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASCVD</b> <b>DEMENTIA</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No	
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>2</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>Manish Mohindra</b>				29c. License number <b>D32014</b>		29d. Date signed (Month, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MANISH MOHINDRA 106 MILFORD ST 50413 SALISBURY MD 21804</b>							
31. Date filed (Month, Day, Year) <b>SEP 07 2000</b>				32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30073

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gerald E. Richter</b>				2. Date of Death Month <b>Sept</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>5:15 am</b>						
	4a. Facility Name (If not institution, give street and number) <b>Carroll Lutheran Village Nursing Home</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>						
Funeral Director	5. Social Security Number <b>216-22-8496</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 3, 1905</b>						
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <b>1</b> Yes <b>2</b> No								
	10e. Street and Number <b>300 St. Luke Cr.</b>				10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>USA</b>						
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Principal/Superintendent</b>		16b. Kind of Business/Industry <b>Public Education</b>								
	17. Father's Name (First, Middle, Last) <b>Gerald Emil Richter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marian Kirkwood</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Amass/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>41 Fitzhugh Ave. Westminster, MD 21157</b>								
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadow Branch Cemetery</b>		20c. Location - City or Town, State <b>Westminster, MD</b>		20d. Date <b>9/4/00</b>						
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Pritts Funeral Home &amp; Chapel, P.A.</b> <b>412 Washington Rd. Westminster, MD 21157</b>										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Bilateral Aspiration Pneumonia</b> Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>1 wk</b> </td> </tr> <tr> <td>b. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____ Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____ Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Bilateral Aspiration Pneumonia</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>1 wk</b>	b. _____ Due to (or as a consequence of):	c. _____ Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Bilateral Aspiration Pneumonia</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>1 wk</b>											
	b. _____ Due to (or as a consequence of):												
	c. _____ Due to (or as a consequence of):												
	d. _____ Due to (or as a consequence of):												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sickle Cell Syndrome, Advanced Renal Failure</b>						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown							
						24e. Was an autopsy performed? <b>1</b> Yes <b>2</b> No							
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No							
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		28. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)											
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No							
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred									
29a. Certifier (Check only one) <b>1</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>037444</b>		29d. Date signed (Month, Day, Year) <b>Sept 5th, 2000</b>							
30. Name and address of person completing cause of death (Item 23a) (Type, Print) <b>Alexander Bogdanovskiy, 205 S. Mainburg, Westminster, MD, 21157</b>													
31. Date filed (Month, Day, Year) <b>SEP 07 2000</b>		32. Registrar's Signature 											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30074

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HENRY B. SHORTLEY

2. Date of Death

Month Day Year  
SEPT 16 2000

3. Time of Death

2:25pm

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

254 14 3001

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 13, 1920

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3333 Coventry Court Drive

10f. Zip Code

21042

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanical Engineer

16b. Kind of Business/Industry

Telephone

17. Father's Name (First, Middle, Last)

Benjamin B. Shortley

18. Mother's Name (First, Middle, Maiden Surname)

Marie Gregain

19a. Informant's Name/Relationship (Type, Print)

Margie Shortley/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3333 Coventry Court Drive Ellicott City, MD 21042

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

9-18-2000 Catonsville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Dona Collins - with

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 2104323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. EMPHYSEMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and DeathSEVERAL  
YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

B. H. MD

29c. License number

D0018317

29d. Date signed (Month, Day, Year)

SEPT 16 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BERNARD P. FARRELL MD  
11055 LITTLE PATIENT PKWY, COLUMBIA, MD 21044

31. Date filed (Month, Day, Year)

SEP 18 2000

32. Registrar's Signature

B. A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30075

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph J. Shockley</b>				2. Date of Death Month <b>September</b> Day <b>5</b> Year <b>2000</b>				3. Time of Death <b>1220</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>				4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>215-36-1485</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) <b>9-15-1913</b>		9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md.</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Mardela Springs</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>10720 Sharptown Road</b>		10f. Zip Code <b>21837</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>		16b. Kind of Business/Industry <b>Vegetables &amp; Grain</b>		17. Father's Name (First, Middle, Last) <b>Louis H. Shockley</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Grace English Shockley</b>		19a. Informant's Name/Relationship (Type, Print) <b>Donna Wilkinson, Niece</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31955 Old Ocean City Rd. Parsonsburg, Md. 21849</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mardela Memorial Cem.</b>		20c. Location - City or Town, State <b>Mardela, Md.</b>		20d. Date <b>9-9-00</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Short Funeral Home, Inc.</b> <b>13 E. Grove St. Delmar, De. 19940</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Robert Collier, M.D.</b>		29c. License number <b>MD H0056197</b>		
29d. Date signed (Month, Day, Year) <b>9/5/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Peninsula Regional Medical Center</b>		31. Date filed (Month, Day, Year) <b>SEP 06 2000</b>		32. Registrar's Signature 		33. Registrar's Name <b>Robert Collier, M.D.</b>		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30076

Alvina Shelton SS# 213 22-7767

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ALVINA SHELTON</b>		2. Date of Death Month <b>September</b> Day <b>6</b> Year <b>2000</b>		3. Time of Death <b>0550</b>	
4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>			4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
5. Social Security Number <b>213-22-7767</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8-5-1914</b>
9. Birthplace (State or Foreign Country) <b>MD.</b>					
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State <b>MD</b>	10b. County <b>SOMERSET</b>	10c. City, Town or Location <b>PRINCESS ANNE</b>			
10e. Street and Number <b>PO BOX 695</b>		10f. Zip Code <b>21853</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOOD PROCESSING</b>		16b. Kind of Business/Industry <b>DULANY</b>	
17. Father's Name (First, Middle, Last) <b>DENNIS JOHNSON SR.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MOSSIE BECKETT JOHNSON</b>		
19a. Informant's Name/Relationship (Type, Print) <b>DORINA JOHNSON-DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13672 BOBTOWN RD PRINCESS ANNE MD, 21853</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TRINITY UMC CEMETARY</b>		20c. Location - City or Town, State <b>9/9/2000 VENTON, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>BENNIE SMITH F/H</b> <b>917-W. ISABELLA ST. SALISBURY, MD. 21801</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Arteriosclerotic Heart Disease</b> Due to (or as a consequence of):  b. <b>Atherosclerosis</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ursepsis, E. coli, Seizure</b> <b>Diarrhea, old CVA -</b> <b>Electrolyte Imbalance</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>257670</b>		29d. Date signed (Month, Day, Year) <b>9-6-2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. L. Evangelista</b> <b>105 Pine Bluff Road #4</b> <b>Salisbury, MD 21801</b>					
31. Date filed (Month, Day, Year) <b>SEP 07 2000</b>		32. Registrar's Signature 			





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State of Maryland / Department of Health and Mental Hygiene

00 30077

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLOTTE M. SPANIER</b>		2. Date of Death Month <b>Sept.</b> Day <b>11,</b> Year <b>2000</b>		3. Time of Death <b>12:40 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Civista Medical Center</b>		4b. City, Town, or Location of Death <b>LaPlata</b>		4c. County of Death <b>Charles</b>
Funeral Director	5. Social Security Number <b>156-03-5290</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>January 4, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>MD</b>		
To Be Completed by Funeral Director	10b. County <b>Charles</b>		10c. City, Town or Location <b>Waldorf</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>510 Adams Lane</b>		10f. Zip Code <b>20602</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>
	16b. Kind of Business/Industry <b>Home</b>		17. Father's Name (First, Middle, Last) <b>James Murphy</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Carbine Murphy</b>
	19a. Intomant's Name/Relationship (Type, Print) <b>Annmarie Kocsis/daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>510 Adams Lane, Waldorf, MD 20602</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Brinsfield-Echols, Home</b>		20c. Location - City or Town, State <b>9/14/00 Charlotte Hall, MD</b>
	21. Signature of Funeral Service Licensee <b>David C. Echols</b>		22. Name and Address of Facility <b>AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD. 20646</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Chronic obstructive Pulmonary Disease</b> years Due to (or as a consequence of): b. <b>Interstitial Lung Disease</b> years Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <b>9/14/00</b>					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>B. Jenkins</b>					
29c. License number <b>D-33426</b>					
29d. Date signed (Month, Day, Year) <b>9-11-00</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>B. Larry Jenkins Jr., M.D. 111 LaGrange Ave. P.O. Box 2665 LaPlata, MD 20646</b>					
31. Date filed (Month, Day, Year) <b>SEP 13 2000</b>					
32. Registrar's Signature <b>B. Jenkins</b>					



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State of Maryland / Department of Health and Mental Hygiene

00 30078

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET ELIZABETH SMOOT</b>			2. Date of Death Month Day Year <b>September 10, 2000</b>		3. Time of Death <b>6:00AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>6205 Bivins Place</b>			4b. City, Town, or Location of Death <b>La Plata</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>217-28-8066</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 17, 1933</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>						
To Be Completed by Funeral Director	Usual Residence of Decedent						
	10a. State <b>MD</b>	10b. County <b>Charles</b>	10c. City, Town or Location <b>La Plata</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>6205 Bivins Place</b>			10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housekeeper</b>		16b. Kind of Business/Industry <b>Domestic</b>		
	17. Father's Name (First, Middle, Last) <b>Joseph Smoot</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Wright Smoot</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Marie Woodland/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>320 Goosecreek Drive, La Plata, MD 20646</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart Cemetery</b>		20c. Location - City or Town, State <b>La Plata, MD.</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>AREHART-ECHOLS FUNERAL HOME, P.A.</b> <b>P.O. BOX 567 LA PLATA, MD. 20646</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cardiomyopathy</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Attending Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D28352</b>		29d. Date signed (Month, Day, Year) <b>September 11, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646</b>							
31. Date filed (Month, Day, Year) <b>SEP 13 2000</b>		32. Registrar's Signature 					

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 30079

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William John Christie Smith</b>				2. Date of Death Month <b>Sept.</b> Day <b>11</b> Year <b>2000</b>		3. Time of Death <b>0 400</b>	
	4a. Facility Name (If not institution, give street and number) <b>3010 Marston Road</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>218-28-0345</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Dec. 24 1923</b>	
	9. Birthplace (State or Foreign Country) <b>Scotland</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State <b>Maryland</b> 10b. County <b>Carroll</b> 10c. City, Town or Location <b>Westminster</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3010 Marston Road</b>	
	10f. Zip Code <b>21157</b>				10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Production Mechanic</b>		16b. Kind of Business/Industry <b>American National Can</b>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Alexander M. Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie Kerr Christie</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ernest F. Sharff II Stepson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4187 Wine Road Westminster, MD 21158</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation, Inc.</b>		20c. Location - City or Town, State <b>Hampstead, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>James B. Covey</b>				22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>CVA</b> Due to (or as a consequence of): b. <b>ASCLD</b> Due to (or as a consequence of): c. <b>Diabetes</b> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>72 hr</b> <b>20 yr</b> <b>10 yr</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>John W. Middleton</b>			
	29c. License number <b>D25443</b>				29d. Date signed (Month, Day, Year) <b>9/11/2000</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John W. Middleton 688 Poole Rd, Westminster Md 21157</b>				31. Date filed (Month, Day, Year) <b>SEP 11 2000</b>			
	32. Registrar's Signature <b>Barbara B. Sparks</b>				33. State Registrar <b>SEP 11 2000</b>			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30080

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Herbert Maurice Stansfield</b>		2. Date of Death Month <b>SEPTEMBER</b> Day <b>7</b> Year <b>2000</b>		3. Time of Death <b>3:05 AM</b>
	4e. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>212-10-9354</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Apr 29, 1915</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Carroll</b>	10c. City, Town or Location <b>Hampstead</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>4108 Hillcrest Avenue</b>		10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machine Operator</b>		16b. Kind of Business/Industry <b>Black &amp; Decker</b>		
	17. Father's Name (First, Middle, Last) <b>Samuel Carter Stansfield</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ida Ellen Elseroad</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Beulah Stansfield, wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4108 Hillcrest Ave, Hampstead, MD 21074</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wesley Cemetery</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>
	21. Signature of Funeral Service Licensee <b>Stevens W. Elmer</b>		22. Name and Address of Facility <b>Eline Funeral Home 934 South Main St, Hampstead, MD 21074</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>2 DAYS</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <b>Francis Khoo</b>		29c. License number <b>D30263</b>		29d. Date signed (Month, Day, Year) <b>9-7-2000</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRANCIS KHOO M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204</b>				
	31. Date filed (Month, Day, Year) <b>SEP 08 2000</b>		32. Registrar's Signature <b>Sparks</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30081

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Joyce Stevenson

2. Date of Death

Month  
Sept.

Day

4

Year

2000

3. Time of Death

12:50PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

213-40-6588

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 17, 1941

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11309 Parkmont Drive

10f. Zip Code

20772

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nursing

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Monroe Rex Bell

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Pinkney

19a. Informant's Name/Relationship (Type, Print)

Francis R. Stevenson - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11309 Parkmont Dr., Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Cemetery

Date

9/8/2000

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Liver Failure

Approximate  
Interval Between  
Onset and Death

8 Days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Metastatic Breast Cancer to Liver

6 Weeks

Due to (or as a consequence of):

Breast Cancer

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stanley A. Schwartz, M.D.

29c. License number

D17368

29d. Date signed (Month, Day, Year)

9/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stanley A. Schwartz, M.D. 5454 Wisconsin Ave., #1345; Bethesda, MD 20815

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 07 2000

32. Registrar's Signature

Stanley A. Schwartz

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30082

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM THOMAS TRUITT		2. Date of Death Month Day Year September 6, 2000		3. Time of Death 2108	
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 220-28-2022	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) SEPT. 12, 1931		9. Birthplace (State or Foreign Country) VIRGINIA			
To Be Completed by Funeral Director	Usual Residence of Decedent		10c. City, Town or Location		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10a. State MARYLAND	10b. County WICOMICO	10c. City, Town or Location FRUITLAND		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number LOT #67 SKYLER DR.		10f. Zip Code 21826		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER	
	16b. Kind of Business/Industry POULTRY		17. Father's Name (First, Middle, Last) GEORGE L. TRUITT, SR.		18. Mother's Name (First, Middle, Maiden Surname) ELLA DAVIS	
	19a. Informant's Name/Relationship (Type, Print) DIANE S. GREEN - DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5112 BLUE MARLIN DR. EDEN, MD 21822			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY		20c. Location - City or Town, State 9/13/00 CAMBRIDGE, MARYLAND	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 705 E. MAIN ST. SALISBURY, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASCD Due to (or as a consequence of): b. Acute Myocardial Infarct Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier MD DME		29c. License number D0054127	29d. Date signed (Month, Day, Year) 9/7/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alon Davis MD DME 3 Bistake Blvd Delmar MD 21875		31. Data filed (Month, Day, Year) SEP 11 2000				
32. Registrar's Signature 						

ORIGINAL




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State of Maryland / Department of Health and Mental Hygiene 00 30083

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LARRY DALE WEST				2. Date of Death Month Day Year SEPT. 07 2000		3. Time of Death 7:00 AM	
	4a. Facility Name (If not institution, give street and number) 1011 LANTERN HILL COURT				4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO	
Funeral Director	5. Social Security Number 233-62-0154		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) 04/14/1939	
	9. Birthplace (State or Foreign Country) WEST VIRGINIA		10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location SALISBURY	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10a. Street and Number 1011 LANTERN HILL COURT		10f. Zip Code 21804		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 5		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DIRECTOR OF OPERATIONS		16b. Kind of Business/Industry AEROSPACE			
	17. Father's Name (First, Middle, Last) WILBERT WEST				18. Mother's Name (First, Middle, Maiden Surname) DOLLIE HAMRICK			
	19a. Informant's Name/Relationship (Type, Print) BARBARA WEST - WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 LANTERN HILL COURT SALISBURY, MD 21804			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAMBRIDGE CREMATORY		20c. Date 9/8/00		20d. Location - City or Town, State CAMBRIDGE, MARYLAND	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Carcinoma of the Esophagus</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined							
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number 024986		29d. Date signed (Month, Day, Year) 9/7/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Reilly MD 560 Riverside Dr. Salisbury Md. 21801							
State Registrar	31. Date filed (Month, Day, Year) SEP 07 2000				32. Registrar's Signature 			





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State of Maryland / Department of Health and Mental Hygiene

00 30084

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIRGINIA MAE WARD			2. Date of Death Month Day Year September 4, 2000		3. Time of Death 09:15 AM	
	4a. Facility Name (If not institution, give street and number) 4421 Smith Road			4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 220-28-2102	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 3, 1933	9. Birthplace (State or Foreign Country) Maryland
	10a. State Maryland			10b. County Wicomico		10c. City, Town or Location Salisbury	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number 4421 Smith Road		10f. Zip Code 21801	
	10g. Citizen of What Country? USA			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper			16b. Kind of Business/Industry State Government		17. Father's Name (First, Middle, Last) Charles C McGee	
	18. Mother's Name (First, Middle, Maiden Surname) Elsie Marshal			19a. Informant's Name/Relationship (Type, Print) William Ward/Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4421 Smith Rd., Salisbury, MD 21801	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Portersville Church Cemetery		20c. Location - City or Town, State 9/8/00 Stockton, MD	
	21. Signature of Funeral Service Licensee Keith R. Doney			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COPD Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier [Signature]		29c. License number H54827	
	29d. Date signed (Month, Day, Year) 9/7/00			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURIEL GIBLIN 106 MILFORD ST SUITE 201 SALISBURY MD 21804		31. Date filed (Month, Day, Year) SEP 07 2000	
	32. Registrar's Signature [Signature]			33. Date of Death SEP 07 2000		34. Date of Death SEP 07 2000	

ORIGINAL

10-2-55

10-2-55

10-2-55  
10-2-55  
10-2-55

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30085

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edmund B White SR

2. Date of Death  
Month Day Year

September 05 2000 8:45pm

3. Time of Death

4a. Facility Name (If not Institution, give street and number)

MERCY HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

215-01-5701

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Apr 18, 1917

9. Birthplace (State or Foreign  
Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Hampstead

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

746 Sportsman Court

10f. Zip Code

21074

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Fork Lift Operator

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

Frank White

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Tyler

19a. Informant's Name/Relationship (Type, Print)

Edmund White, Jr, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

746 Sportsman Ct, Hampstead, MD 21074

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Crypt20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

9/11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stevens W. Elmer

22. Name and Address of Facility

Eline Funeral Home

934 South Main St, Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac arrhythmia

Due to (or as a consequence of):

b. Heart failure

Due to (or as a consequence of):

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Coronary artery disease

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dr. David M.D.

29c. License number

P11627

29d. Date signed (Month, Day, Year)

September 05, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARA DINITS University of Maryland Medical System 22 Greene street Baltimore  
MD 21201State  
Registrar

31. Date filed (Month, Day, Year)

SEP 08 2000

32. Registrar's Signature

Diana B Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30086

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT H. WEBB

2. Date of Death  
Month Day Year

Sept. 11, 2000

3. Time of Death

12:05 PM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

066-16-5549

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

April 23, 1915

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

LaPlata

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1 Magnolia Drive

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No WWII  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Commercial Artist

16b. Kind of Business/Industry

Comic Books

17. Father's Name (First, Middle, Last)

Thomas Miller Webb

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Howard

19a. Informant's Name/Relationship (Type, Print)

Ronald L. Webb/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6797 Amherst Road, Bryans Road, Maryland 20616

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Presbyterian Cemetery 09+14-2000 Lynchburg, Virginia

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

MARK G. BROHAWN M00053

22. Name and Address of Facility

The Hunt Funeral Home, Inc.  
P.O. Box 156, Waldorf, Maryland 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

few months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Ashvin J. Patel

29c. License number

D44436

29d. Date signed (Month, Day, Year)

SEPT 11 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ashvin J. Patel, 6 Industrial Park Dr. #B, Waldorf, MD 20601

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

Benita S. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30087

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence E. Zimmerman, Sr.

2. Date of Death

Month Day Year  
Sept. 8 2000

3. Time of Death

9:50 Am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Hidden Treasures Nursing Home

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

216-14-7228

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 23, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Marriottsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7529 Ridge Road

10f. Zip Code

21784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Construction

16b. Kind of Business/Industry

Walter E. Crismer, Co.

17. Father's Name (First, Middle, Last)

James Arthur Zimmerman

18. Mother's Name (First, Middle, Maiden Surname)

Nora Alice Wood

19a. Informant's Name/Relationship (Type, Print)

Scott Zimmerman Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

302 St. Andrews Lane Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Taylorsville Cemetery

Date

9/11/2000 Taylorsville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.  
1212 W. Old Liberty Road Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Pancreatic CA metastasized to lungs*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0052815

29d. Date signed (Month, Day, Year)

9/8/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

686-C Poole Rd. Westminster, MD 21157

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30088

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Leon Bond</b>				2. Date of Death Month <b>9</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>14:58</b>		
	4a. Facility Name (If not institution, give street and number) <b>Lorien Nursing Home</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard County</b>		
Funeral Director	5. Social Security Number <b>219-40-0898</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>7 26 41</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Joppatown</b>		
Usual Residence of Decedent		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>412A Dembytown Rd.</b>		10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Cotton Construction Company</b>		17. Father's Name (First, Middle, Last) <b>Joseph Leon Bond</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Chase</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Esther Bond - Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>412A Dembytown Rd. Joppatown, Md. 21085</b>		20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Vashell Cemetery</b>		20c. Location - City or Town, State <b>9-25-2000 Baltimore, Maryland</b>	
21. Signature of Funeral Service <b>[Signature]</b>		22. Name and Address of Facility <b>Miller's Metropolitan Chapel, P.C. 1639 N. Broadway Balto. Md. 21213</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CHRONIC RENAL FAILURE</b> Due to (or as a consequence of): <b>HYPERTENSION</b> Due to (or as a consequence of): <b>CHRONIC RENAL FAILURE</b> Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		23c. Was an autopsy performed? <b>1</b> Yes <b>2</b> No	
23d. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No		24a. Certifier (Check only one) <b>2</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		24b. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24c. Time of Injury <b>M</b>		24d. Describe how injury occurred	
24e. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24f. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24g. Time of Injury <b>M</b>		24h. Describe how injury occurred		24i. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>	
24j. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24k. Time of Injury <b>M</b>		24l. Describe how injury occurred		24m. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24n. Date of Injury (Month, Day, Year) <b>9/21/00</b>	
24o. Time of Injury <b>M</b>		24p. Describe how injury occurred		24q. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24r. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24s. Time of Injury <b>M</b>	
24t. Describe how injury occurred		24u. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24v. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24w. Time of Injury <b>M</b>		24x. Describe how injury occurred	
24y. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24z. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24aa. Time of Injury <b>M</b>		24ab. Describe how injury occurred		24ac. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>	
24ad. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24ae. Time of Injury <b>M</b>		24af. Describe how injury occurred		24ag. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24ah. Date of Injury (Month, Day, Year) <b>9/21/00</b>	
24ai. Time of Injury <b>M</b>		24aj. Describe how injury occurred		24ak. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24al. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24am. Time of Injury <b>M</b>	
24an. Describe how injury occurred		24ao. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24ap. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24aq. Time of Injury <b>M</b>		24ar. Describe how injury occurred	
24as. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24at. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24au. Time of Injury <b>M</b>		24av. Describe how injury occurred		24aw. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>	
24ax. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24ay. Time of Injury <b>M</b>		24az. Describe how injury occurred		24ba. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24bb. Date of Injury (Month, Day, Year) <b>9/21/00</b>	
24bc. Time of Injury <b>M</b>		24bd. Describe how injury occurred		24be. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24bf. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24bg. Time of Injury <b>M</b>	
24bh. Describe how injury occurred		24bi. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24bj. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24bk. Time of Injury <b>M</b>		24bl. Describe how injury occurred	
24bm. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24bn. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24bo. Time of Injury <b>M</b>		24bp. Describe how injury occurred		24bq. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>	
24br. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24bs. Time of Injury <b>M</b>		24bt. Describe how injury occurred		24bu. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24bv. Date of Injury (Month, Day, Year) <b>9/21/00</b>	
24bv. Time of Injury <b>M</b>		24bw. Describe how injury occurred		24bx. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24by. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24bz. Time of Injury <b>M</b>	
24ca. Describe how injury occurred		24cb. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24cc. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24cd. Time of Injury <b>M</b>		24ce. Describe how injury occurred	
24cf. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24cg. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24ch. Time of Injury <b>M</b>		24ci. Describe how injury occurred		24cj. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>	
24ck. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24cl. Time of Injury <b>M</b>		24cm. Describe how injury occurred		24cn. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24co. Date of Injury (Month, Day, Year) <b>9/21/00</b>	
24cp. Time of Injury <b>M</b>		24cq. Describe how injury occurred		24cr. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24cs. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24ct. Time of Injury <b>M</b>	
24cu. Describe how injury occurred		24cv. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24cw. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24cx. Time of Injury <b>M</b>		24cy. Describe how injury occurred	
24cz. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24da. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24db. Time of Injury <b>M</b>		24dc. Describe how injury occurred		24dd. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>	
24de. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24df. Time of Injury <b>M</b>		24dg. Describe how injury occurred		24dh. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24di. Date of Injury (Month, Day, Year) <b>9/21/00</b>	
24di. Time of Injury <b>M</b>		24dj. Describe how injury occurred		24dk. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24dl. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24dm. Time of Injury <b>M</b>	
24dn. Describe how injury occurred		24do. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24dp. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24dq. Time of Injury <b>M</b>		24dr. Describe how injury occurred	
24ds. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24dt. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24du. Time of Injury <b>M</b>		24de. Describe how injury occurred		24df. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>	
24df. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24dg. Time of Injury <b>M</b>		24dh. Describe how injury occurred		24di. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24dj. Date of Injury (Month, Day, Year) <b>9/21/00</b>	
24dj. Time of Injury <b>M</b>		24dk. Describe how injury occurred		24dl. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24dm. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24dn. Time of Injury <b>M</b>	
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24df. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24dg. Time of Injury <b>M</b>		24dh. Describe how injury occurred		24di. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24dj. Date of Injury (Month, Day, Year) <b>9/21/00</b>	
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24dn. Describe how injury occurred		24do. Location (Street and Number or Rural Route Number, City or Town, State) <b>6830 Hornum Dr. BMD, Md 21232</b>		24dp. Date of Injury (Month, Day, Year) <b>9/21/00</b>		24dq. Time of Injury <b>M</b>		24dr. Describe how injury occurred	
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24dj. Time of Injury <b>M</b>		24dk. Describe how injury occurred		24dl. Location (Street					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30089

AMEND#5 PER F.H. G787 9-25-2000 JAB

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Diana K Browne</b>		2. Date of Death Month Day Year <b>SEP 20 2000</b>		3. Time of Death <b>1225</b>
	4e. Facility Name (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>219-28-1922</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>77</b> Yrs.	If Under 1 Year Months Days <b>77</b>	If Under 24 Hrs. Hours Min. <b>77</b>
	8. Date of Birth (Month, Day, Year) <b>MAY 17, 1923</b>		9. Birthplace (State or Foreign Country) <b>NY</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>910 RAMBLING DRIVE</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MUSIC TEACHER</b>		16b. Kind of Business/Industry <b>EDUCATION</b>	
17. Father's Name (First, Middle, Last) <b>ALBERT KURKHILL</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>HANNAH FEINBLUM</b>			
19a. Informant's Name/Relationship (Type, Print) <b>DAVID C. BROWNE / HUSBAND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>910 RAMBLING DRIVE - BALTIMORE, MD 21228</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORP.</b>		20c. Location - City or Town, State <b>9/22/00 TOWSON, MD</b>	
21. Signature of Funeral Service Licensee <b>Scott M. Cottle</b>		22. Name and Address of Facility <b>SCL LEVINSON &amp; BRCS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Pneumonia, aspiration</b>			Approximate Interval Between Onset and Death <b>10 days</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):			
		b. <b>Intracranial hemorrhage into mass</b>			<b>30 days</b>
		Due to (or as a consequence of):			
		c. <b>Intracranial mass, unknown etiology</b>			<b>30 days</b>
		Due to (or as a consequence of):			
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<b>Mitral valve regurgitation</b>					
<b>Ischemic cardiomyopathy</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
23a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>George Hoke MD, Attending</b>		29c. License number <b>D53249</b>		29d. Date signed (Month, Day, Year) <b>(09) September 20, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>George Hoke St Agnes Hospital - Balto, Md.</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <b>[Signature]</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30090

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOUGLAS CRAWLEY</b>		2. Date of Death Month Day Year <b>SEPTEMBER 2, 2000</b>		3. Time of Death <b>03:03</b>
	4a. Facility Name (If not institution, give street and number) <b>MERCY MEDICAL CENTER ER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE CITY</b>
Funeral Director	5. Social Security Number <b>217-38-3383</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b>	8. Date of Birth (Month, Day, Year) <b>01-11-42</b>	
	9. Birthplace (State or Foreign Country) <b>VA</b>		10. Usual Residence of Decedent		
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>13 N. Wolfe Street</b>		10f. Zip Code <b>21231</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>	
16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Line</b>		17. Kind of Business/Industry <b>General Motors</b>		18. Decedent's Name (First, Middle, Maiden Surname) <b>Thomas F. Crawley</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Mary Yancey</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1520 Lochwood Road Baltimore, Maryland 21218</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem.</b>		20c. Location - City or Town, State <b>MD</b>	
21. Signature of Funeral Service Licensee <b>Glady Wanner</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>HYPOXIA</b> Due to (or as a consequence of): <b>PULMONART EMBOLI</b> Due to (or as a consequence of): <b>METASTATIC RENAL CELL CANCER</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>DECLINED</b>		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Amal Mattu, MD</b>		29c. License number <b>D50544</b>	
29d. Date signed (Month, Day, Year) <b>SEPTEMBER 21, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MERCY MEDICAL CENTER ER</b>			
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

ORIGINAL

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CHARTER

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WEST MEDICAL CENTER ST. LOUIS, MISSOURI

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2002

WEST MEDICAL CENTER  
ST. LOUIS, MISSOURI  
2002



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30091

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Donald Sylvester Campbell, Sr</i>				2. Date of Death Month <i>SEPTEMBER</i> Day <i>19</i> Year <i>2000</i>		3. Time of Death <i>7:15 PM</i>		
	4a. Facility Name (If not institution, give street and number) <i>Stella Maris At Mercy</i>				4b. City, Town, or Location of Death <i>Baltimore City</i>		4c. County of Death <i>N/A</i>		
Funeral Director	5. Social Security Number <i>218-32-2869</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>64</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <i>September 14, 1936</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>Lansdowne</i>	10c. City, Town or Location <i>N/A</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <i>200 First Avenue</i>			10f. Zip Code <i>21227</i>		10g. Citizen of What Country? <i>U. S. A</i>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Machinist</i>		16b. Kind of Business/Industry <i>Paper Products</i>				
	17. Father's Name (First, Middle, Last) <i>Robert Dominic Campbell</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Anita Marietta Jackson</i>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Richard Matthew Campbell / Brother</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>311 Cedar Run Place Catonsville, Maryland 21228</i>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>The Green Mount Cemetery</i>		20c. Location - City or Town, State <i>9/25/2000 Baltimore, Maryland</i>				
	21. Signature of Funeral Service Licensee <i>Margaret Gilmore Henson</i>		22. Name and Address of Facility <i>Margaret Gilmore Henson, mortician 5240 Reisterstown Road Baltimore, Maryland 21215</i>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic Pancreatic Cancer</i> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>HOSPICE</i>									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Dr. [Signature]</i>				29c. License number <i>D40854</i>		29d. Date signed (Month, Day, Year) <i>9/22/2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202</i>									
31. Date filed (Month, Day, Year) <i>SEP 25 2000</i>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

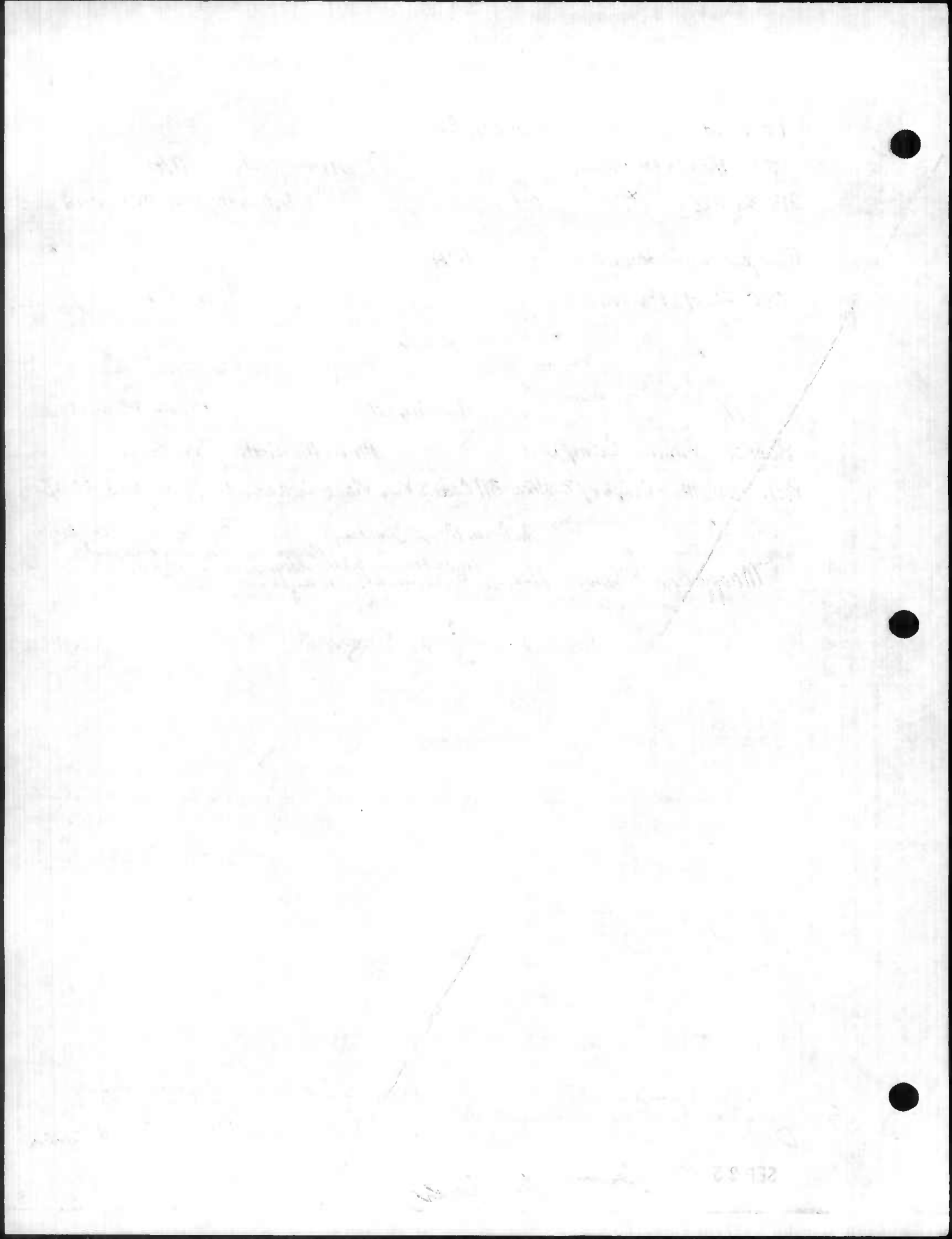
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30092

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ESSIE E. CLARK				2. Date of Death Month Day Year September 21, 2000				3. Time of Death 2:56 AM	
	4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTO.				4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-30-6070		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) 01-26-1933		9. Birthplace (State or Foreign Country) MD	
	10a. State MD				10b. County N/A		10c. City, Town or Location BALTIMORE			
To Be Completed by Funeral Director	10e. Street and Number 2928 OAKLEY AVENUE				10f. Zip Code 21215		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) DAYCARE PROVIDER				16b. Kind of Business/Industry CHILDCARE	
	17. Father's Name (First, Middle, Last) JESSIE BATTLE				18. Mother's Name (First, Middle, Maiden Surname) LUVENIA HALL					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ALVIN CLARK/HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2928 OAKLEY AVENUE, BALTO., MD. 21215					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT. ZION		Date 9/26/2000		20c. Location - City or Town, State BALTO., MD.			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee James A. Morton				22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CORONARY ARTERY DISEASE Due to (or as a consequence of): b. DIABETES MELLITUS, TYPE 2 Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION HYPERLIPIDEMIA				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Gary J. Kerkvliet, MD							
	29c. License number D45708		29d. Date signed (Month, Day, Year) 9/22/00							
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARY J. KERKVLIT, MD 2435 W. BELVEDERE BALTIMORE MD 21215									
	31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature [Signature]							

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30093

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PAULINE CHASKELSON</b>		2. Date of Death Month Day Year <b>SEPTEMBER 21, 2000</b>		3. Time of Death <b>11:22AM</b>
	4a. Facility Name (If not Institution, give street and number) <b>JEWISH CONVALESCENT HOME</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>495-14-4952</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>OCT. 3, 1906</b>		9. Birthplace (State or Foreign Country) <b>UKRAINE</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>47 PENNY LANE</b>			10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
17. Father's Name (First, Middle, Last) <b>HARRY ROSEN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MIRIAM SCHOICHT</b>		
19a. Informant's Name/Relationship (Type, Print) <b>TED CHASKELSON / SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>47 PENNY LANE - BALTIMORE, MD 21209</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHEVRA KADISHA</b>		20c. Location - City or Town, State <b>ST. LOUIS, MO</b>	
21. Signature of Funeral Service Licensee <i>Michael Bryan</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>MYOCARDIAL INFARCTION IMMEDIATE</b> Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D15146</b>		29d. Date signed (Month, Day, Year) <b>September 21, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR SUNSHINE MD, 9428 PK-Hts Ave, Balt, MD 21215</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30094

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES DUDLEY</b>				2. Date of Death Month <b>SEP</b> Day <b>20</b> Year <b>2000</b>		3. Time of Death <b>11:35 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BonSecour Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>217-32-9450</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>06-05-36</b>	
	9. Birthplace (State or Foreign Country) <b>VA</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent								
10a. State <b>MD</b>			10b. County <b>NA</b>			10c. City, Town or Location <b>Baltimore</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>4708 Annatana Avenue</b>			10f. Zip Code <b>21206</b>		
10g. Citizen of What Country? <b>USA</b>			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>NA</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Distributor</b>			16b. Kind of Business/Industry <b>Everfresh Company</b>			17. Father's Name (First, Middle, Last) <b>Samuel Davis</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Marion Dudley</b>			19a. Informant's Name/Relationship (Type, Print) <b>Sallie V. Dudley</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4708 Anntana Avenue Baltimore, Maryland 21206</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery 09-25-2000 Lansdowne, MD</b>			20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Shock</b> Due to (or as a consequence of): <b>b. Cerebrovascular Accident</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. { Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)			28b. Time of Injury <b>M</b>			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how Injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>D26256</b>		
29d. Date signed (Month, Day, Year) <b>9/20/00</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BonSecour Hospital</b> <b>Dr. Bich Duong 2000 W. Baltimore Street Baltimore, MD. 21223</b>			31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		
32. Registrar's Signature 			33. State Registrar <b>SEP 25 2000</b>					

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 30095

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Benjamin Deal</u>				2. Date of Death Month <u>9</u> / Day <u>19</u> / Year <u>2000</u>		3. Time of Death <u>12:36pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>Baltimore Veterans Affairs Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>218-18-9376</u>		6. Sex <u>1</u> M <u>2</u> F		7. Age (In yrs. last birthday) <u>76</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>September 15, 1924</u>	
	9. Birthplace (State or Foreign Country) <u>Maryland</u>		10a. State <u>Maryland</u>		10b. County <u>Talbot</u>		10c. City, Town or Location <u>Easton</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <u>1</u> Yes <u>2</u> No		10e. Street and Number <u>28 Londonderry Drive</u>		10f. Zip Code <u>216011</u>		10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates: <u>1943-46</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>Unknown</u> College (1-4 or 5+) <u>College</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Disabled</u>		16b. Kind of Business/Industry <u>Never Worked</u>		17. Father's Name (First, Middle, Last) <u>Walter Deal, Sr.</u>	
	18. Mother's Name (First, Middle, Maiden Surname) <u>Elizabeth Blocks</u>		19a. Informant's Name/Relationship (Type, Print) <u>Richard Harrison</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5042 Endman Avenue, Baltimore, MD 21205</u>		20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <u>MD Veterans Cemetery</u>		20c. Date <u>Sept. 22</u>		20d. Location - City or Town, State <u>Crownsville, Maryland</u>		21. Signature of Funeral Service Licensee <u>[Signature]</u>	
	22. Name and Address of Facility <u>Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122</u>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>a. Myocardial Infarction</u> Due to (or as a consequence of): <u>b. Pneumonia</u> Due to (or as a consequence of): <u>c. Catatonic Schizophrenia</u> Due to (or as a consequence of): <u>d. Dementia</u>		Approximate Interval Between Onset and Death <u>2 days</u> <u>2 weeks</u> <u>years</u> <u>years</u>		23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No		25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No		26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)	
	27. Manner of Death <u>1</u> Natural <u>2</u> Accident <u>3</u> Suicide <u>4</u> Homicide <u>5</u> Pending Investigation <u>6</u> Could not be determined		28a. Date of Injury (Month, Day Year) <u>9/19/00</u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No	
State Registrar	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier <u>[Signature] MD Resident PGY1</u>		29c. License number <u>AU4176435H13126</u>		29d. Date signed (Month, Day, Year) <u>9/19/00</u>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Vikram Hatti 6091 Majors Ln #5, Columbia, MD 21045</u>	
31. Date filed (Month, Day, Year) <u>SEP 25 2000</u>		32. Registrar's Signature <u>[Signature]</u>		33. Date of Death (Month, Day, Year) <u>SEP 25 2000</u>		34. Date of Filing (Month, Day, Year) <u>SEP 25 2000</u>		

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State of Maryland / Department of Health and Mental Hygiene

00 30096

Amend Item # 31, G787, 9/25/2000, gap

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel DeSoto, Sr.		2. Date of Death Month Day Year September 20, 2000		3. Time of Death 3:00 PM
	4a. Facility Name (If not institution, give street and number) 6846 Boston Avenue		4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 125-26-8668	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs. 70	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) April 27, 1930		9. Birthplace (State or Foreign Country) Puerto Rico		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State Maryland	10b. County Baltimore	10c. City, Town or Location Dundalk		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 6846 Boston Avenue		10f. Zip Code 21222		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Puerto Rican
	14. Race - American Indian, Black, White, etc. Specify: Hispanic		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 Years College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Engineering Steel Industry		
	17. Father's Name (First, Middle, Last) Not Known		18. Mother's Name (First, Middle, Maiden Surname) Alicia Not Known		
	19a. Informant's Name/Relationship (Type, Print) Mrs. Catherine DeSoto (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6846 Boston Avenue Dundalk, Maryland 21222		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Park		20c. Location - City or Town, State Middle River, MD
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of):				
	b. ISCHEMIC CARDIOMYOPATHY Due to (or as a consequence of):				
	c. CORONARY ARTERY DISEASE Due to (or as a consequence of):				
	d.				
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS				
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]			
29c. License number D45643		29d. Date signed (Month, Day, Year) 9/20/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARK KELEMEN MD 4940 EASTERN AVE BAL, MD 21224					
31. Date filed (Month, Day, Year) 9/22/2000		32. Registrar's Signature [Signature]			



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State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 30097

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Doris E. Edwards</b>				2. Date of Death Month Day Year <b>SEPTEMBER 21 2000</b>		3. Time of Death <b>0140 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>214-26-5409</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05-24-22</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2313 Ruskin Avenue</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th Grade</b> College (1-4 or 5+) <b>NA</b>				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>in home</b>	
17. Father's Name (First, Middle, Last) <b>James H. Hursey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Osie V. Walker</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gloria J. Howard</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21213</b> <b>1723 N. Collington Avenue Baltimore, MD.</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem.</b>		Date <b>09-26-2000</b>		20c. Location - City or Town, State <b>MD. Owings Mill</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEPSIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>2 DAYS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>AT 2438946</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 21, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL M WOLF MD 201 E. UNIVERSITY PKWY BALTIMORE, MD 21218</b>								
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 00 30098

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Foyles</b>				2. Date of Death Month <b>Sept.</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>3:00 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>2817 Presstman St.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>212-30-6019</b>	6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth Month <b>May</b> Day <b>27</b> Year <b>1934</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No			
	10e. Street and Number <b>2817 Presstman St.</b>			10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Engineer</b>			16b. Kind of Business/Industry <b>Baltimore City</b>			
	17. Father's Name (First, Middle, Last) <b>Edward Foyles</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (Wife) <b>Mrs Myrtle Swinson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2817 Presstman St. Balto. Md. 21216</b>				
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park</b>		20c. Location - City or Town, State <b>Balto. Md.</b>		20d. Date <b>9/27/2000</b>		
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 12222 W. North Ave. Balto. Md. 21216</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pancreatic Cancer stage IV</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								
	23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Anemia, CORD.</b>						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)							
27. Manner of Death <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Jon K. Minford, MD</b>		29c. License number <b>D30573</b>		29d. Date signed (Month, Day, Year) <b>9-19-00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jon K. Minford, MD 2200 North Columbia MD 21045</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <b>Barbara B. Spauls</b>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30099

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Freda B. Ganske

2. Date of Death

Month Day Year  
September 22, 2000 4:15pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

179-20-9564

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 5, 1927

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

4835 Bushey Road

10f. Zip Code

21784

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

General Employee

16b. Kind of Business/Industry

Black &amp; Decker

17. Father's Name (First, Middle, Last)

Raymond Bittle

18. Mother's Name (First, Middle, Maiden Surname)

Annie Krumrine

19a. Informant's Name/Relationship (Type, Print)

Raymond W. Ganske Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4835 Bushey Road Sykesville, MD 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Grace Methodist Ch. Cem. 9/26/2000 Hampstead, MD

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jama B. Conway

22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.  
1212 W. Old Liberty Road Winfield, MD 21784

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY DISTRESS SYNDROME

25 DAYS

Due to (or as a consequence of):

b. SEPSIS

25 DAYS

Due to (or as a consequence of):

c. OVARIAN CANCER

5 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Joseph Buscema, MD

29c. License number

D0025274

29d. Date signed (Month, Day, Year)

09-23-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH BUSCEMA, MD 10755 FALLS ROAD, SUITE 230, LUTHERVILLE MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Benita A. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30100

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Evelyn C Green</i>				2. Date of Death Month <i>September</i> Day <i>15</i> Year <i>2000</i>		3. Time of Death <i>4:18 pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Center</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death	
Funeral Director	5. Social Security Number <i>218-22-1856</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>74</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>8 13 26</i>		9. Birthplace (State or Foreign Country) <i>North Carolina</i>
	Usual Residence of Decedent							
10a. State <i>Md</i>		10b. County <i>Queens Anne</i>		10c. City, Town or Location <i>Chester</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <i>211 Riverside Drive</i>				10f. Zip Code <i>21619</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>#</i> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher</i>		16b. Kind of Business/Industry <i>Queen Anne's County Public School</i>		
17. Father's Name (First, Middle, Last) <i>IVORY Gentry</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Artie Street</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Tampa Green - Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>211 Riverside Drive Chester, Md. 21619</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Union Wesleyan Cemetery 9/23/00</i>			20c. Location - City or Town, State <i>Chester, MD</i>			
21. Signature of undersigned Service person <i>Jeff Miller</i>				22. Name and Address of Facility <i>Miller's Metropolitan Chapel, P.C. 1922 Forest Drive Annapolis, Md. 21401</i>				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Sepsis</i> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Dua to (or as a consequence of):</i> <i>c. Dua to (or as a consequence of):</i> <i>d.</i>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <i>AU417643512446</i>		29d. Date signed (Month, Day, Year) <i>September 18, 2000</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>BABAK MOEINOLMAKI 22 South Greene Street, Baltimore, Maryland 21201</i>								
31. Date filed (Month, Day, Year) <i>SEP 25 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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State of Maryland / Department of Health and Mental Hygiene

00 30101

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Morris Gaymon</b>				2. Date of Death Month Day Year <b>September 14, 2000</b>		3. Time of Death <b>12:20 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>1800 Hollins Street, Apartment 122 West</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>216-34-3756</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 29, 1937</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1800 Hollins St. APT. 122</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Afro-American</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry <b>N/A</b>					
17. Father's Name (First, Middle, Last) <b>Willard Gaymon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pattie Fowkles</b>					
19a. Informant's Name/Relationship (Type, Print) (sister) <b>Mrs. Joan Howard</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28 Enchanted Hills Rd. Owings Mills, Md. 21117</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Location - City or Town, State <b>Balto, Md.</b>		20d. Date <b>9/29/2000</b>			
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216</b>					
23a. Pertinent enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 14, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified in accordance with the regulations.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



SEP 2 1955

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30102

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRENE SOPHIA HANKEWYCZ</b>				2. Date of Death Month Day Year <b>September 22 2000</b>		3. Time of Death <b>01:22 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>2007 East Lombard Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-30-2549</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 14, 1915</b>		9. Birthplace (State or Foreign Country) <b>UKRAINE</b>
	Usual Residence of Decedent							
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2007 E. LOMBARD STREET</b>				10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>			16b. Kind of Business/Industry <b>DOMESTIC</b>	
17. Father's Name (First, Middle, Last) <b>STEPHAN SCZUTKA</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SOPHIA UNKNOWN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ROMAN HANKEWYCZ/ SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3607 HAMILTON AVENUE, BALTIMORE, MARYLAND 21214</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. MICHAEL'S UKRAINIAN</b>		Date <b>9/26/00</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LILLY &amp; ZEILER INC. FUNERAL HOME</b> <b>1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <u>Atherosclerotic Cardiovascular Disease</u></b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 22, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30103

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WALTER J. HAYNES				2. Date of Death Month Day Year September 22 00		3. Time of Death 10:10 AM									
	4a. Facility Name (If not institution, give street and number) MERCY MEDICAL CENTER				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death									
Funeral Director	5. Social Security Number 579-10-9418	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4-7-1916	9. Birthplace (State or Foreign Country) N.C.									
	Usual Residence of Decedent															
To Be Completed by Funeral Director	10a. State Md	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
	10e. Street and Number 3201 Sequoia Avenue			10f. Zip Code 21215		10g. Citizen of What Country? U S A										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2 years Self Employed		16b. Kind of Business/Industry Variety Store											
	17. Father's Name (First, Middle, Last) Chalmers Haynes			18. Mother's Name (First, Middle, Maiden Surname) Mattie Wallace												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Walter J. Brewer- Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 Ashland Avenue Charlotte, N.C. 28205												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 9-27-00	20c. Location - City or Town, State Randallstown, Md										
	21. Signature of Funeral Service Licensee <i>John B. Johnson</i>		22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>Septic shock</u></td> <td rowspan="4">           Due to (or as a consequence of):             b. <u>perforation of cecum</u>             c.             d.         </td> <td rowspan="4">           Approximate Interval Between Onset and Death             40 hours             ~46 hours         </td> </tr> <tr><td colspan="2"></td></tr> <tr><td colspan="2"></td></tr> <tr><td colspan="2"></td></tr> </table>							Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Septic shock</u>	Due to (or as a consequence of):  b. <u>perforation of cecum</u>  c.  d.	Approximate Interval Between Onset and Death  40 hours  ~46 hours					
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>Septic shock</u>	Due to (or as a consequence of):  b. <u>perforation of cecum</u>  c.  d.	Approximate Interval Between Onset and Death  40 hours  ~46 hours													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Colon cancer - Left hemicolectomy 9/9/00</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier <i>Dr. Johnson</i>			29c. License number D39986			29d. Date signed (Month, Day, Year) 9/22/00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ira J. Levine 301 St. Paul Place Suite 912 Baltimore MD 21202																
State Registrar	31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature <i>Benjamin B. Sparks</i>													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30104

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nellie Hall</b>		2. Date of Death Month <b>Sept.</b> Day <b>16</b> Year <b>2000</b>		3. Time of Death <b>12:25 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Wesley Nursing Home</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>218-48-2678</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Aug. 20, 1908</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>N/A</b>
	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>4223 Rokeby Rd.</b>		10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. <b>Specify: Afro-American</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Beautician</b>		16b. Kind of Business/Industry <b>Self-employed</b>
	17. Father's Name (First, Middle, Last) <b>James Thomas</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Smith</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Ruth Love (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2218 Ashburton St. Balto. Md. 21216</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Maryland National</b>		20c. Location - City or Town, State <b>Laurel, Md.</b>
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Atherosclerotic Vascular Disease</b>					Approximate Interval Between Onset and Death
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>R. Liberty, MD</b>		29c. License number <b>D21464</b>		29d. Date signed (Month, Day, Year) <b>9/18/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT LIBERTO, MD 3508 BANK ST BALTO, MD 21224</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

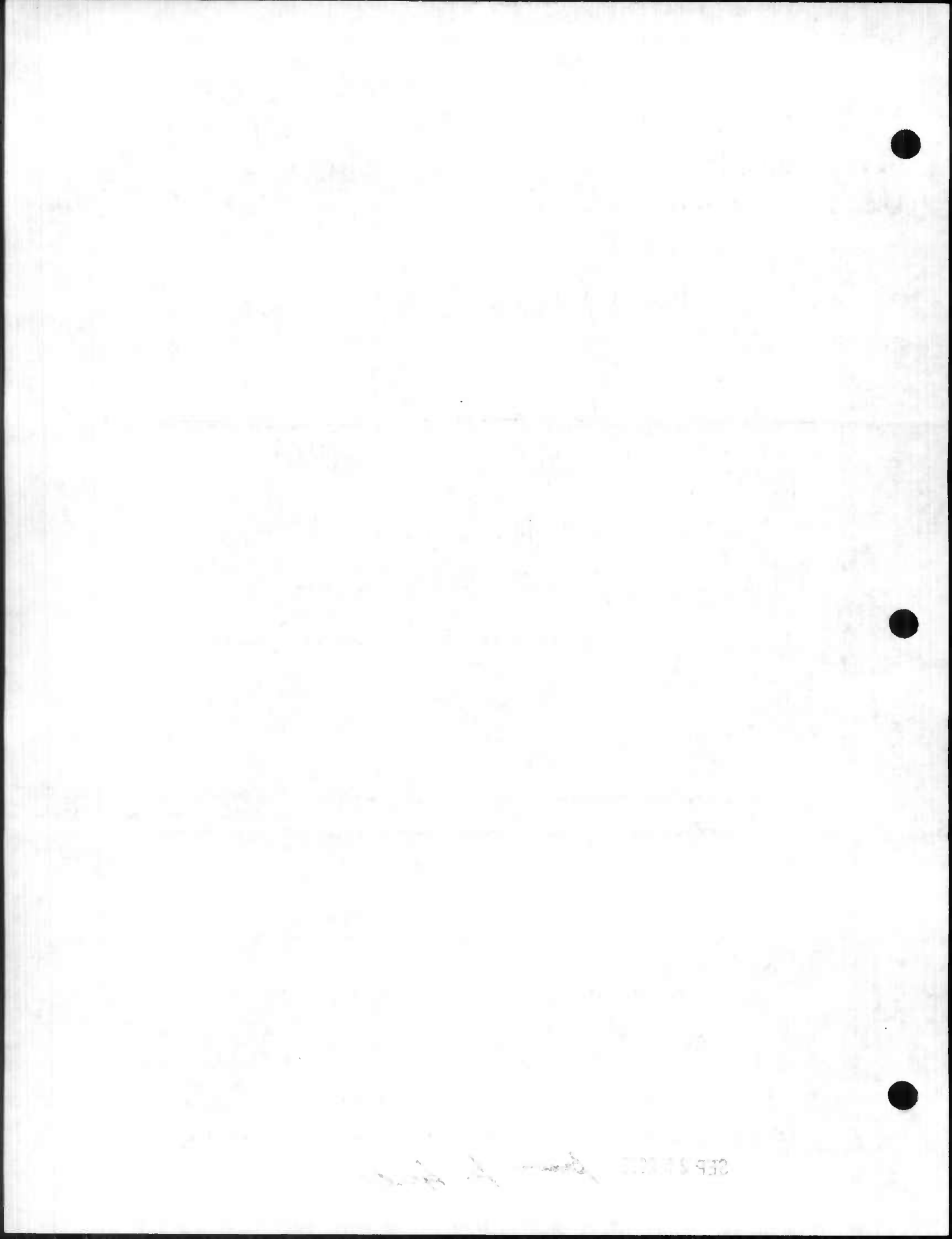
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30105

## Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) <b>Marlene Kennedy</b>		2. Date of Death Month Day Year <b>Sept. 22, 2000</b>		3. Time of Death <b>5:10am</b>	
4a. Facility Name (If not institution, give street and number) <b>Hospice of Baltimore Gilchrist Ctn.</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>219-32-6941</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>06-02-36</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1339 E. North Avenue</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>2yrs.</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerical</b>		16b. Kind of Business/Industry <b>Benefit Concept.</b>			
17. Father's Name (First, Middle, Last) <b>James Sewell, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Josephine Moore</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Gwendolyn Grimes</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3317 Lawnview Avenue Baltimore, Maryland 21213</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem.</b>		20c. Location - City or Town, State <b>MD.</b>	
21. Signature of Funeral Service Licensee <b>Wladimir W. W.</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>gastric cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>W.A. Riley, MD</b>		29c. License number <b>025205</b>		29d. Date signed (Month, Day, Year) <b>September 22, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley G.B.M.C. 6701 N. Charles St. Balto. md 21204</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <b>James B. Sparks</b>			

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30106

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Diana Killebrew				2. Date of Death Month Day Year September 17, 2000				3. Time of Death 6:00 A.M.		
	4a. Facility Name (If not institution, give street and number) Northwest Hospital Center				4b. City, Town, or Location of Death Randallstown				4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 212-70-7503		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	8. Date of Birth (Month, Day, Year) 2-2-1958		9. Birthplace (State or Foreign Country) Md				
	Usual Residence of Decedent										
10a. State Md		10b. County Baltimore		10c. City, Town or Location Owings Mills				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 5002 Willow Branch Way				10f. Zip Code 21117		10g. Citizen of What Country? U S A					
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled				16b. Kind of Business/Industry Unk			
17. Father's Name (First, Middle, Last) Walter Killebrew				18. Mother's Name (First, Middle, Maiden Surname) Lucy Gray							
19a. Informant's Name/Relationship (Type, Print) Walter J. Killebrew-Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5002 Willow Branch Way Owings Mills, Md 21117							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) King Memorial Park		Date 9-21-00		20c. Location - City or Town, State Randallstown, Md			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215							
23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>CARDIOMEGALY</u> Due to (or as a consequence of): b. <u>TETRALOGY OF FALLOT ASSOCIATED WITH ADENOCARCINOMA OF LEFT LUNG</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 17, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) SEP 22 2000		32. Registrar's Signature 									
State Registrar											



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State of Maryland / Department of Health and Mental Hygiene

00 30107

AMEND ITEM: #20B-C PER F.H. G787 9-25-00 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Annie L. Morrison</b>				2. Date of Death Month Day Year <b>September 19, 2000</b>		3. Time of Death <b>8:32 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Maryland General Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>244-86-0509</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>07-16-46</b>	
	9. Birthplace (State or Foreign Country) <b>NC</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1902 Division Street</b>		10f. Zip Code <b>21217</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>				16b. Kind of Business/Industry <b>Baltimore Washington Inter.</b>		17. Father's Name (First, Middle, Last) <b>Dallas Whittington</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Ann Swann</b>				19a. Informant's Name/Relationship (Type, Print) <b>Amos M. Whittington</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4404 Kavon Avenue Baltimore, Maryland 21206</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>VOSHELL MEMORIAL GARDENS</b>		20c. Location - City or Town, State <b>King Mem. Pk. Cem. 09-23-2000 Randallstown, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory Failure</b> Due to (or as a consequence of): <b>Severe Metabolic Acidosis</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>89390</b>		29d. Date signed (Month, Day, Year) <b>9/19/00</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Benjamin Krpichak, M.D. 40 Maryland General Hospital</b>				31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 				33. State Registrar <b>SEP 25 2000</b>			
	34. State Registrar <b>SEP 25 2000</b>				35. State Registrar <b>SEP 25 2000</b>			

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State of Maryland / Department of Health and Mental Hygiene 00 30108

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) VIOLEA McDONALD			2. Date of Death Month Day Year 9 17 2000			3. Time of Death 8:10 AM			
	4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL			4b. City, Town, or Location of Death BALTIMORE			4c. County of Death NA			
Funeral Director	5. Social Security Number 217-22-0174		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) 12-22-27		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County NA		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 1100 Winchester Street				10f. Zip Code 21217		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown NA		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Disabled			16b. Kind of Business/Industry Disabled				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Thomas Brown				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Jackson					
	19a. Informant's Name/Relationship (Type, Print) Yvonne Taylor				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1100 Winchester Street Baltimore, Maryland 21217					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arbutus Mem. Pk. Cem.		20c. Location - City or Town, State 09-25-2000 Arbutus, MD					
	21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE MYOCARDIAL INFARCTION Due to (or as a consequence of) b. HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of) c. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Due to (or as a consequence of) d.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier [Signature] ROSITA R. CRUZ M.D.		29c. License number D00303 SS		29d. Date signed (Month, Day, Year) September 17, 2000					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSITA R. CRUZ M.D. BON SECOURS HOSPITAL									
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature [Signature]								

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State of Maryland / Department of Health and Mental Hygiene

00 30109

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>William</u>			2. Date of Death Month <u>September</u> Day <u>24</u> Year <u>2000</u>			3. Time of Death <u>0845</u>					
	4a. Facility Name (If not institution, give street and number) <u>JOHNS HOPKINS BAYVIEW</u>			4b. City, Town, or Location of Death <u>BALTIMORE</u>			4c. County of Death <u>N/A</u>					
Funeral Director	5. Social Security Number <u>218-18-9048</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>76</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Jan. 22, 1924</u>		9. Birthplace (State or Foreign Country) <u>MARYLAND</u>			
	Usual Residence of Decedent			10a. State <u>MD.</u>			10b. County <u>N/A</u>			10c. City, Town or Location <u>BALTIMORE</u>		
To Be Completed by Funeral Director	10a. State			10b. County			10c. City, Town or Location			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <u>617 S. EATON STREET</u>			10f. Zip Code <u>21224</u>			10g. Citizen of What Country? <u>U.S.A.</u>					
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>1943-46</u>			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>INSPECTOR</u>			16b. Kind of Business/Industry <u>BETHLEHEM STEEL</u>					
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>WILLIAM M. MERRITT, SR.</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>KATHERINE BRIEMAN</u>			19a. Informant's Name/Relationship (Type, Print) <u>ANNA MERRITT/ WIFE</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>617 S. EATON STREET, BALTIMORE, MARYLAND 21224</u>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>SACRED HEART OF JESUS</u>			20c. Location - City or Town, State <u>9/27/00 BALTIMORE, MARYLAND</u>					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <u>LILLY &amp; ZEILER INC. FUNERAL HOME</u> <u>700 S. CONKLING STREET, BALTIMORE, MARYLAND 21224</u>			23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Heart failure</u> Due to (or as a consequence of): <u>Coronary artery disease</u> Due to (or as a consequence of): <u></u> Due to (or as a consequence of): <u></u> Due to (or as a consequence of): <u></u>			Approximate Interval Between Onset and Death <u>5 years</u> <u>20 years</u>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Heart failure</u> Due to (or as a consequence of): <u>Coronary artery disease</u> Due to (or as a consequence of): <u></u> Due to (or as a consequence of): <u></u> Due to (or as a consequence of): <u></u>			23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		
	28a. Date of Injury (Month, Day Year)			28b. Time of Injury <u>M</u>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <u>D24334</u>			29d. Date signed (Month, Day, Year) <u>Sept 24, 2000</u>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>THOMAS FINUCANE</u> <u>4940 EASTERN AVENUE, BALTIMORE, MARYLAND</u>			31. Date filed (Month, Day, Year) <u>SEP 25 2000</u>			32. Registrar's Signature 					

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30110

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Clara Belle Malott				2. Date of Death Month Day Year September 21 2000				3. Time of Death 10:56 AM				
	4a. Facility Name (If not Institution, give street and number) 4201 Townsend Avenue				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A				
Funeral Director	5. Social Security Number 213-26-4939		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.				
	8. Date of Birth (Month, Day, Year) Aug. 04 1916		9. Birthplace (State or Foreign Country) Ohio		10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore				
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4201 Townsend Avenue		10f. Zip Code 21225		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Custodian			
16b. Kind of Business/Industry Public Schools		17. Father's Name (First, Middle, Last) Martin Rovenstine		18. Mother's Name (First, Middle, Maiden Surname) Sylvia Greene		19a. Informant's Name/Relationship (Type, Print) Frances Rush (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7823 B & A Blvd. Glen Burnie, Md. 21060					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Cemetery		Date Sept 23 2000		20c. Location - City or Town, State Glen Burnie, Maryland		21. Signature of Funeral Service Licensee <i>Musculi Stallings</i>		22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, Maryland 21122			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Cerebrovascular Accident</i> Due to (or as a consequence of):  b. <i>Hypertension</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death  8/27/00 4/93		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Ischemic Heart Disease</i> <i>Chronic Obstructive Pulmonary Disease</i>		23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier <i>[Signature]</i>		29c. License number D31744		29d. Date signed (Month, Day, Year) 9/21/2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Harold Hebert, M.D. 4710 Pennington Ave, Baltimore, MD. 21226		31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature <i>[Signature]</i>									

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30111

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Warren L. Miller		2. Date of Death Month Day Year SEPTEMBER 21 2000		3. Time of Death 8:06 p.m.
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL CENTER		4b. City, Town, or Location of Death ROSEDALE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 215-48-3596	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (in yrs. last birthday) 48 Yrs.	8. Date of Birth (Month, Day, Year) August 18, 1952	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent		10a. State MD		10b. County Baltimore
To Be Completed by Funeral Director	10c. City, Town or Location Perry Hall		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 9457 Bellhall Drive		10f. Zip Code 21236		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Regional Manager
	16b. Kind of Business/Industry Norton Lilly International Steamship		17. Father's Name (First, Middle, Last) Martin E. Miller		18. Mother's Name (First, Middle, Maiden Surname) Alma E. Malchodi
	19a. Informant's Name/Relationship (Type, Print) Deborah L. Miller-wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9457 Bellhall Dr., Baltimore, MD 21236		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Memorial Park		20c. Location - City or Town, State Baltimore, MD
	21. Signature of Funeral Service Licensee William G. Dau		22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 10 years		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of certifier Deputy		29c. License number D18667	
29d. Date signed (Month, Day, Year) September 22, 2000		30. Name and address of person who completes cause of death (Item 23a) (Type, Print) Philip M. Hedges, MD Shock Trauma 22 S. Greene St. Baltimore, Md 21201			
State Registrar	31. Date filed (Month, Day, Year) SEP 25 2000	32. Registrar's Signature B. Sparks			

Mr

H.

264cm per 55,5000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30112

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EMIL MAIER</b>		2. Date of Death Month Day Year <b>September 21 2000</b>		3. Time of Death <b>6:25 pm</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>215-28-4739</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>OCT. 15, 1917</b>		9. Birthplace (State or Foreign Country) <b>GERMANY</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>3106 MARNAT ROAD</b>			10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>UPHOLSTERER</b>		16b. Kind of Business/Industry <b>FURNITURE</b>	
17. Father's Name (First, Middle, Last) <b>ISIDORE MAIER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>FLORENZ WOLF</b>		
19a. Informant's Name/Relationship (Type, Print) <b>KURT MAIER / BROTHER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3106 MARNAT ROAD - BALTIMORE, MD 21208</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHEVRA AHAVAS CHESED CEMETERY</b>		20c. Location - City or Town, State <b>9/22/00 RANDALLSTOWN, MD</b>	
21. Signature of Funeral Service Director <i>Michael Bruger</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Gastrointestinal Bleed</b> Due to (or as a consequence of): b. <b>Pulmonary Aspiration</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to Immediate Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last {					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b> <b>Congestive Heart Failure</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and Title of certifier <i>Broderick Franklin</i>		29c. License number <b>043476</b>		29d. Date signed (Month, Day, Year) <b>September 21, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2401 Belvedere Ave., Baltimore, MD 21215 (Sinai Hospital)</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30113

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sylvia Mack</b>		2. Date of Death Month Day Year <b>Sept. 18, 2000</b>		3. Time of Death <b>2:15 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Ravenwood Nursing Center</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>219-72-6674</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>43</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>July 12, 1957</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2300 Callow Ave.</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. <b>African American</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>		16b. Kind of Business/Industry <b>Belvedere Hotel</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>George A. Mack,</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Glenda Hall</b>		
	19a. Informant's Name/Relationship (Type, Print) (mother) <b>Mrs. Glenda Mack</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1513 N. Stricker St. Balto. Md. 21217</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Location - City or Town, State <b>Balto. Md.</b>
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>		
	23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acquired Immune Deficiency</b> Due to (or as a consequence of): Approximate Interval Between Onset and Death <b>many years</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <b>9/22/2000</b>					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Christa Lamping</b>					
29c. License number <b>D32263</b>					
29d. Date signed (Month, Day, Year) <b>9/19/2000</b>					
30. Name and address of person who completed cause of death (Item 28a) (Type, Print) <b>C. LAMPING 1940 W BALTIMORE 21223</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>					
32. Registrar's Signature <b>B. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30114

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Evelyn Pickett</b>				2. Date of Death Month <b>Sept.</b> Day <b>22</b> Year <b>2000</b>			3. Time of Death <b>3:15 AM</b>			
	4e. Facility Name (If not institution, give street and number) <b>Westminster Nursing Center</b>				4b. City, Town, or Location of Death <b>Westminster</b>			4c. County of Death <b>Carroll</b>			
Funeral Director	5. Social Security Number <b>220-34-7439</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>98</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 1 1902</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>1234 Washington Road</b>		10f. Zip Code <b>21157</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) <b>Hostess</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Senior Club</b>			16b. Kind of Business/Industry			
	17. Father's Name (First, Middle, Last) <b>William Grimes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Belle Unknown</b>						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>William Welsh Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6317 Oakland Mills Road Eldersburg, MD 21784</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pleasant Ridge Cemetery</b>			20c. Location - City or Town, State <b>9/25/2000 Woodbine, MD</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Jama B Coray</b>				22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Acute myocardial infarction</b> Due to (or as a consequence of): b. <b>ASCVD</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>1 hr</b> <b>20 yrs</b>						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Panding investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Jama B Coray</b>			29c. License number <b>D25443</b>		29d. Date signed (Month, Day, Year) <b>9/22/2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John W. Middleton 688 Poole Road, Westminster md 21157</b>				31. Date filled (Month, Day, Year) <b>SEP 25 2000</b>			32. Registrar's Signature <b>Benny B Sparks</b>			

James B. Smith



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30115

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDNA PETERSON</b>				2. Date of Death Month <b>SEPTEMBER</b> Day <b>19</b> Year <b>2000</b>				3. Time of Death <b>8:08 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>				4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>220-22-1035</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>3-9-1905</b>		9. Birthplace (State or Foreign Country) <b>S.C.</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1838 W. Franklin Street</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U S A</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b>		College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>		16b. Kind of Business/Industry <b>Child's Restaurant</b>				
17. Father's Name (First, Middle, Last) <b>Cornelius Taylor</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Carolia</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Frances Taylor- Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3521 Millvale Road Randallstown, Md 21244</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>9-23-00</b>		20c. Location - City or Town, State <b>Randallstown, Md</b>		
21. Signature of Funeral Service Licensee <b>Walter Edmond</b>				22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Avenue Baltimore, Md 21215</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>UROSEPSIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Respiratory Failure; Coagulopathy; Chronic Atrial Fibrillation; Renal Failure; Dehydration</b>				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Respiratory Failure; Coagulopathy; Chronic Atrial Fibrillation; Renal Failure; Dehydration</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. Place of Death (Check only one)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Orlando B. Edwards MD</b>		29c. License number <b>D19502</b>		29d. Date signed (Month, Day, Year) <b>September 19, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ORLANDO B. EDWARDS MD</b> <b>NORTHWEST HOSPITAL CENTER</b> <b>RANDALLSTOWN MD 21133</b>				31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>				32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30116

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James A. Parker</b>				2. Date of Death Month <b>September</b> Day <b>19</b> Year <b>2000</b>		3. Time of Death <b>8:24 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216-44-1648</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 25, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>5202 Liberty Heights Ave.</b>		10f. Zip Code <b>21207</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cement Worker</b>				16b. Kind of Business/Industry <b>Self-employed</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Gassaway Theodore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Randall</b>			
	19a. Informant's Name/Relationship (Type, Print) (wife) <b>Mrs. Irene Parker</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5202 Liberty Heights Ave. Balto, Md. 21207</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>			
	20c. Location - City or Town, State <b>Balto, Md.</b>				20d. Date <b>9/23/2000</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>				22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216</b>			
	23a. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Advanced Parkinson's disease</b> <b>b. Arteriosclerotic heart disease</b> <b>c. old cerebral infarct</b> <b>d. Prostate Carcinoma</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	23c. Approximate Interval Between Onset and Death				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M			
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Joseph L. Russ</b>			
	29c. License number <b>D10613</b>				29d. Date signed (Month, Day, Year) <b>9-20-2000</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAPHAEL PEREZ-MORA 1777 BELSTERSDOWN Rd. BALTIMORE MD 21208</b>				31. Data filed (Month, Day, Year) <b>SEP 25 2000</b>			
	32. Registrar's Signature <b>B. Sparks</b>				33. State Registrar <b>SEP 25 2000</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

00 30117

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>LENNIE QUEEN</u>		2. Date of Death Month <u>9</u> Day <u>20</u> Year <u>00</u>		3. Time of Death <u>1718</u>
	4a. Facility Name (If not institution, give street and number) <u>BON SECOURS HOSPITAL</u>		4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>218-22-2483</u>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>75</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>10-20-1924</u>		9. Birthplace (State or Foreign Country) <u>MD</u>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <u>MD</u>	10b. County <u>N/A</u>	10c. City, Town or Location <u>BALTIMORE</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <u>1510 W. MOSHER ST.</u>		10f. Zip Code <u>21217</u>		10g. Citizen of What Country? <u>USA</u>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>TEACHER</u>		16b. Kind of Business/Industry <u>EDUCATION</u>		
	17. Father's Name (First, Middle, Last) <u>ISAIAH QUEEN</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>DAISY SIMMONS</u>		
	19a. Informant's Name/Relationship (Type, Print) <u>MORRIS QUEEN/BROTHER</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9706 SOUTHALL RD. RANDALLSTOWN, MD 21133</u>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>ARBUTUS MEM PARK</u>		20c. Location - City or Town, State <u>9/26/2000 BALTO., MD.</u>
	21. Signature of Funeral Service Licensee <u>James A. Morton</u>		22. Name and Address of Facility <u>JAMES A. MORTON &amp; SONS F.H., INC</u> <u>1701 LAURENS ST., BALTO., MD. 21217</u>		
Physician /Medical Examiner	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <u>Asystole</u>				<u>1 hour</u>
	Due to (or as a consequence of): <u>Subacute Myocardial Infarction</u>				<u>3 days</u>
	Due to (or as a consequence of): <u>Myocardial Perforation Effusion</u>				<u>2 weeks</u>
To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>Brachycephalic Airway</u>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Coronary Heart Failure</u> <u>Chronic Fibrosis</u>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <u>M</u>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <u>[Signature]</u> MD		29c. License number <u>D30408</u>		29d. Date signed (Month, Day, Year) <u>9/20/00</u>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>3100 TOWANDA AVE BALTIMORE MD 21215</u>				
	31. Date filed (Month, Day, Year) <u>SEP 25 2000</u>		32. Registrar's Signature <u>[Signature]</u>		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30118

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Daniel Rodrigues			2. Date of Death Month Day Year Sept. 21 2000			3. Time of Death 5:00 PM								
	4a. Facility Name (If not institution, give street and number) 207 Frederick Ave.			4b. City, Town, or Location of Death Mt. Airy			4c. County of Death Carroll								
Funeral Director	5. Social Security Number 575-28-9507		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) June 10 1931		9. Birthplace (State or Foreign Country) Hawaii						
	Usual Residence of Decedent														
10a. State Maryland		10b. County Carroll		10c. City, Town or Location Mt. Airy				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number 207 Frederick Ave.				10f. Zip Code 21771			10g. Citizen of What Country? United States								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Puerto-Rican			14. Race - American Indian, Black, White, etc. Specify: Portugese							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Jungle Figher & Medic				16b. Kind of Business/Industry Army							
17. Father's Name (First, Middle, Last) Domingo Rodrigues					18. Mother's Name (First, Middle, Maiden Surname) Isabella Estrella										
19a. Informant's Name/Relationship (Type, Print) Margaret Anne Rodrigues Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Frederick Ave. Mt. Airy, MD 21771										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.			20c. Location - City or Town, State 9/27/2000 Arlington, VA									
21. Signature of Funeral Service Licensee James B. Gray					22. Name and Address of Facility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease - 1982 b. VASCULAR DISEASE - (18 years) c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier Jayant Anand		29c. License number DIG934		29d. Date signed (Month, Day, Year) 9/25/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAYANT ANAND, 3108 WYMAN PARK DR BALTIMORE MD 21211															
31. Date filed (Month, Day, Year) SEP 25 2000			32. Registrar's Signature B. Sparks												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30119

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Doris Rose				2. Date of Death Month Day Year SEPTEMBER 23, 2000				3. Time of Death 3:37 AM	
	4a. Facility Name (If not institution, give street and number) Stella Maris Hospice				4b. City, Town, or Location of Death Baltimore				4c. County of Death n/a	
Funeral Director	5. Social Security Number 219-26-7204		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 60 Yrs.		8. Date of Birth (Month, Day, Year) 10/04/1939		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Baltimore		10c. City, Town or Location Arbutus				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 5534 Gayland Rd.				10f. Zip Code 21227		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hairdresser			16b. Kind of Business/Industry Cosmetology		
	17. Father's Name (First, Middle, Last) Britton E. Brown				18. Mother's Name (First, Middle, Maiden Surname) Edna Leizear					
	19a. Informant's Name/Relationship (Type, Print) Deborah Hammond/daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 69 Wind Bluff Ct. Owings Mills, MD 21117					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Park		20c. Date 09/26/00		20d. Location - City or Town, State Elkridge, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. Breast Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) hospice										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 										
29c. License number D40854										
29d. Date signed (Month, Day, Year) 9/23/2000										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Rosenberg 301 St Paul Pl Baltimore 21202										
31. Date filed (Month, Day, Year) SEP 25 2000										
32. Registrar's Signature 										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30120

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FREDERICK B. RUDO</b>		2. Date of Death Month Day Year <b>SEPTEMBER 21, 2000</b>		3. Time of Death <b>12:45PM</b>
	4a. Facility Name (If not institution, give street and number) <b>3410 DEEP WILLOW AVENUE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>213-38-7041</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>MAR.23, 1918</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>3410 DEEP WILLOW AVENUE</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DENTIST</b>		16b. Kind of Business/Industry <b>DENTISTRY</b>		
	17. Father's Name (First, Middle, Last) <b>DAVID RUDO</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MATILDA DAVIS</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>JAY Y. RUDO / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3712 GARDENVIEW ROAD - BALTIMORE, MD 21208</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LUBAWITZ NUSACH ARI CEMETERY</b>		20c. Location - City or Town, State <b>ROSEDALE, MD</b>
	21. Signature of Funeral Service 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>ASCVD</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <b>9/22/00</b>					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>016941</b>		29d. Date signed (Month, Day, Year) <b>9/22/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Samuel E. Benesh 21 Crossroads Dr Owings Mills, Md</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30121

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Elizabeth Rhodes				2. Date of Death Month Day Year Sept. 21 2000				3. Time of Death 0220		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 579-48-3251		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 69 Yrs.		8. Date of Birth (Month, Day, Year) March 23, 1931		9. Birthplace (State or Foreign Country) Washington, DC		
	Usual Residence of Decedent										
10a. State MD		10b. County Montgomery		10c. City, Town or Location Kensington				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 9925 East Bexhill Drive				10f. Zip Code 20895				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) William Chatfield Looker				18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Dalton Gaddis							
19a. Informant's Name/Relationship (Type, Print) Kenneth L. Rhodes (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9925 East Bexhill Drive, Kensington, MD 20895							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Hill Cemetery		Date 09/26 2000		20c. Location - City or Town, State Washington, DC					
21. Signature of Funeral Service Licensee Michael P. Keetta				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401							
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebral Vascular Accident Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier [Signature]				29c. License number D55187		29d. Date signed (Month, Day, Year) September 21, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aimee Y. 64 Franklin St. Annapolis, MD 21401											
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature [Signature]									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





or Print in Black Indelible Ink. Assure All Copies Are Legible.

of Maryland / Department of Health and Mental Hygiene

00 30122

Amended Item#13 per FHC787 9/25/2000 EW

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GLADYS SMITH

2. Date of Death

September 22, 2000

3. Time of Death

1554

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

212-06-5479

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 8, 1922

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4307 WENTWORTH RD.

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

ARCHIE SPEAKS

18. Mother's Name (First, Middle, Maiden Surname)

MARY MORGAN

19a. Informant's Name/Relationship (Type, Print)

MARIAN HARRINGTON-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4009 MAINE AVE BALTIMORE, MARYLAND 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN CEMETERY

Date

9/27/00

20c. Location - City or Town, State

WOODLAWN, MARYLAND

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC CARDIOMYOPATHY

Approximate Interval Between Onset and Death

3 years.

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Several years

Due to (or as a consequence of):

c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Several yrs.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS - TYPE II

PERIPHERAL ARTERIAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Osei-Musu MD

29c. License number

D24089

29d. Date signed (Month, Day, Year)

09/23/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adrian Osei-Musu MD, 5710 WABASH AVE. BALT. MD 21215

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Pl Known as Smith, Gladys  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



LAND  
HOME  
12-63

3 year  
2 year  
1 year  
1/2 year

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30123

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Kayla Renae Swan				2. Date of Death Month Day Year September 19, 2000				3. Time of Death 0010		
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis				4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number NONE		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days 4		8. Date of Birth (Month, Day, Year) Sept. 15, 2000		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie				10d. Inside City Limits XX Yes 2 <input type="checkbox"/> No			
10e. Street and Number 213 5th Avenue, S.W.				10f. Zip Code 21061				10g. Citizen of What Country? United States			
11. Marital Status XX Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) Benjamin Charles Swan				18. Mother's Name (First, Middle, Maiden Surname) Jessica Lauren Schellenshlager							
19a. Informant's Name/Relationship (Type, Print) Jessica Schellenshlager/mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 213 5th Ave., SW, Glen Burnie, MD 21061							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		Date 9/23/00		20c. Location - City or Town, State Baltimore, Maryland					
21. Signature of Funeral Service Licensee Michael P. Kutta				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave., Annapolis, Maryland 21401							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.										Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) a. severe respiratory distress syndrome 3 days Due to (or as a consequence of):											
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. intrauterine growth restriction 3 days Due to (or as a consequence of):											
c. extreme prematurity 3 days Due to (or as a consequence of):											
d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Suzanne Randfleisch M.D.				29c. License number H42733		29d. Date signed (Month, Day, Year) September 20, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suzanne Randfleisch, M.D., 2001 Medical Parkway, Annapolis, MD 21401											
31. Date filed (Month, Day, Year)		32. Registrar's Signature									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30124

amend item 3,23a,27, per me G788 10/25/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Sonia Sickle				2. Date of Death Month Day Year SEPTEMBER 22, 2000				3. Time of Death A.M. P.M. 03:32 P.M.		
	4a. Facility Name (If not Institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death N/a		
Funeral Director	5. Social Security Number 215-34-7793		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) Jan. 27, 1937		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore		
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 4851 Carmella Dr.		10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry Accounting						
	17. Father's Name (First, Middle, Last) Michael A. Romeo				18. Mother's Name (First, Middle, Maiden Surname) Rebecca E. Cannon						
	19a. Informant's Name/Relationship (Type, Print) Tina M. Sickle / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4851 Carmella Dr. Baltimore, MD. 21227						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lakeview Memorial Park		Date 9-25-00		20c. Location - City or Town, State Sykesville, MD				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOMEGLY AND SCATTERED MYOCYTE HYPERTROPHY Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
					24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) SEPTEMBER 22, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore H. King 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature 									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30125

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Adam Sykes</b>		2. Date of Death Month Day Year <b>September 19 2000</b>		3. Time of Death <b>03:58 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>N/B 695 East of Exit 2</b>		4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>
Funeral Director	5. Social Security Number <b>218-84-3575</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>32</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>12-18-1967</b>		9. Birthplace (State or Foreign Country) <b>Md</b>		
Usual Residence of Decedent					
10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>4201 Bonner Road</b>			10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U S A</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>1 year</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Baltimore City</b>	
17. Father's Name (First, Middle, Last) <b>Freddie Bryant</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Shirley A. Parks</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Anita Sykes- Wife</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4201 Bonner Road Baltimore, Md 21216</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>9-26-00 Randallstown, Md</b>	
21. Signature of Funeral Service Licensee <b>John B. Johnson</b>		22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Baltimore, Md 21215</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
23c. <b>COMPRESSORIAL ASPHYXIA AND LOWER EXTREMITY INJURIES</b>		23d. Describe how injury occurred <b>DRIVER OF DUMP TRUCK INVOLVED IN MOTOR VEHICLE ACCIDENT</b>			
23e. <b>ROADWAY</b>		23f. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/B 695 EAST OF EXIT 2, GLENBURNIE, MD</b>			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>9/19/00</b>		28b. Time of Injury <b>1430 PM</b>	
28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>DRIVER OF DUMP TRUCK INVOLVED IN MOTOR VEHICLE ACCIDENT</b>			
28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) <b>ROADWAY</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>N/B 695 EAST OF EXIT 2, GLENBURNIE, MD</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>MARY G. RIPLEY, M.D.</b>		29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>September 20, 2000</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature <b>P. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30126

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Spears</b>		2. Date of Death Month Day Year <b>September 18, 2000</b>		3. Time of Death <b>10:04 AM</b>														
	4a. Facility Name (If not institution, give street and number) <b>Singi Hospital of Baltimore</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death														
Funeral Director	5. Social Security Number <b>220-24-4612</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.														
	8. Date of Birth (Month, Day, Year) <b>07 04 24</b>		9. Birthplace (State or Foreign Country) <b>N.C.</b>																
Usual Residence of Decedent																			
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>															
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																			
10e. Street and Number <b>1102 Druid Hill Ave Apt 402</b>			10f. Zip Code <b>21201</b>		10g. Citizen of What Country? <b>U.S.A.</b>														
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:															
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>																			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry <b>Disabled</b>															
17. Father's Name (First, Middle, Last) <b>Beulah Spears</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jeanette Dunlap</b>																	
19a. Informant's Name/Relationship (Type, Print) <b>Hazeline Evans-Niece</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5205 Belleville Ave, Baltimore Md 21207</b>																	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>9/23/2000 Randallstown, Md</b>															
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>																	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><b>Sepsis</b></td> <td>Due to (or as a consequence of):</td> <td rowspan="4"></td> </tr> <tr> <td>b.</td> <td><b>Peritonitis</b></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Sepsis</b>	Due to (or as a consequence of):		b.	<b>Peritonitis</b>	Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Sepsis</b>	Due to (or as a consequence of):																
	b.	<b>Peritonitis</b>	Due to (or as a consequence of):																
	c.		Due to (or as a consequence of):																
	d.		Due to (or as a consequence of):																
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation, CVA, Diabetes Mellitus, Anemia, Dysphagia, Hypertension</b>																			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>															
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred															
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. Signature and title of certifier 		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>September 18, 2000</b>															
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYAM KASHI, D.O. Singi Hospital of Baltimore</b>																			
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature 																	

HELEN SPEARS

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural" or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified in accordance with the law.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30127

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sandra Walker</b>				2. Date of Death Month Day Year <b>SEPTEMBER 19, 2000</b>				3. Time of Death <b>21:30</b>		
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>				4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>214-74-9725</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>11-11-61</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>2317 Callow Avenue</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4 or 5+) <b>NA</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>			16b. Kind of Business/Industry <b>Company</b>				
17. Father's Name (First, Middle, Last) <b>Avon Outlaw</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Walker</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Mary Walker</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2317 Callow Avenue Baltimore, Maryland 21217</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem. 09-23-2000 Randallstown,</b>			Date <b>MD</b>		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>						
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>HEMORRHAGIC STROKE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier  <b>BARROCAS, MD</b>					29c. License number <b>RES 000</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 19, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALEX BARROCAS, MD SINAI HOSPITAL OF BALTIMORE</b>											
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

known as: SANDRA WALKER



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State of Maryland / Department of Health and Mental Hygiene

00 30128

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph Frederick Winhauer</b>				2. Date of Death Month Day Year <b>SEPTEMBER 21 2000</b>		3. Time of Death <b>1502 HRS</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hosp.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-30-0227</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 9, 1932</b>	
	9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md.</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severn</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7959 Telegraph Rd.</b>		10f. Zip Code <b>21144</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Designer</b>		16b. Kind of Business/Industry <b>Floral</b>		
17. Father's Name (First, Middle, Last) <b>George Winhauer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred J. Harvey</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Barbara M. Nichols niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8017 Gough St. Baltimore Md. 21224</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory, or other place) <b>Cedar Hill Cem.</b>		Date <b>Sept. 25 2000</b>		20c. Location - City or Town, State <b>Glen Burnie</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222</b>				
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>ENTEROBACTER PNEUMONIA</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>18 DAYS</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. <b>BRONCHOALVEOLAR CARCINOMA</b> Due to (or as a consequence of):					<b>21 DAYS</b>	
		c. Due to (or as a consequence of):						
		d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>AT 2438946</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 21, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL M WOLF MD 201 E. UNIVERSITY PKWY BALTIMORE, MD 21218</b>								
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature 						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30129

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LENORE

WEINBLATT

2. Date of Death  
Month  
SeptemberDay  
21Year  
20003. Time of Death  
1020 AM

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

141-16-0132

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

FEB. 21, 1920

9. Birthplace (State or Foreign  
Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

35 STONEHENGE CIRCLE

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

HARRY

18. Mother's Name (First, Middle, Maiden Surname)

GOLDENBERG

ROSE

GOLDBERGER

19a. Informant's Name/Relationship (Type, Print)

MORRIS WEINBLATT / HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

35 STONEHENGE CIRCLE - BALTIMORE, MD 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BALTIMORE HEBREW CEMETERY 9/22/00 REISTERSTOWN, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael Bryner

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - BALTIMORE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. CVA  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

7 days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. HTN  
Due to (or as a consequence of):

unknown

c. Atrial Fibrillation  
Due to (or as a consequence of):

unknown

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Matthei

29c. License number

RES000

29d. Date signed (Month, Day, Year)

September 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John A. Matthei 2401 W. Belvedere 21215 Baltimore, MD

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





State of Maryland / Department of Health and Mental Hygiene 00 30130  
Certificate of Death Reg. No.

Reg. No.

**Division of Vital Records, P.O. Box 68760,**

2014

10/26/12

10/26/12

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State of Maryland / Department of Health and Mental Hygiene

00 30131

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALTER S. ZEBROWSKI</b>				2. Date of Death Month Day Year <b>SEPT. 22, 2000</b>				3. Time of Death <b>9:15 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3403 ESTHER PLACE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-24-7197</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>JAN. 26, 1928</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		Usual Residence of Decedent		10a. State <b>MD.</b>		10b. County <b>N/A</b>	
10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3403 ESTHER PLACE</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates <b>1942-44</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LONGSHOREMAN</b>		16b. Kind of Business/Industry <b>SHIPPING</b>		17. Father's Name (First, Middle, Last) <b>ANTHONY ZEBROWSKI</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>JOSEPHINE GAWRONSKA</b>		19a. Informant's Name/Relationship (Type, Print) <b>ROSALIE ZEBROWSKI / WIFE</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>122 N. KENWOOD AVENUE, BALTIMORE, MARYLAND 21224</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAYVIEW CREMATORY</b>		20c. Location - City or Town, State <b>9/26/00 BALTIMORE, MARYLAND</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>LILLY &amp; ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>CEREBROVASCULAR ACCIDENT WITH LEFT HEMIPARESIS</b> Due to (or as a consequence of): b. <b>MALNUTRITION</b> Due to (or as a consequence of): c. <b>DELTATITIS ULLER</b> Due to (or as a consequence of): d. <b>RECURRENT URINARY TRACT INFECTION</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D27188</b>		29d. Date signed (Month, Day, Year) <b>9/22/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sarindithullah 2 Market Place Baltimore MD 21224</b>		
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>		32. Registrar's Signature 		State Registrar		Division of Vital Records, P.O. Box 68760,		Baltimore, Maryland 21215-0020		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30132  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUBY C. AIELLO</b>				2. Date of Death Month <b>September</b> Day <b>7</b> Year <b>2000</b>		3. Time of Death <b>7:00PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Civista Medical Center</b>				4b. City, Town, or Location of Death <b>LaPlata</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>236-30-1363</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>June 13, 1922</b>	9. Birthplace (State or Foreign Country) <b>West VA.</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Charles</b>	10c. City, Town or Location <b>La Plata</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>300 Hartford Street</b>			10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Operator</b>		16b. Kind of Business/Industry <b>Telephone</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Carl Cooley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maude DePew Cooley</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Sharon Beland/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6022 Red Wolf Place, Waldorf, MD 20603</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Memorial Gar.</b>		20c. Location - City or Town, State <b>9/11/00 Waldorf, Maryland</b>		20d. Date	
	21. Signature of Funeral Service Licensee <b>David C. Echols</b>		22. Name and Address of Facility <b>AREHART-ECHOLS FUNERAL HOME, P.A. P.O. BOX 567 LA PLATA, MD 20646</b>		22. M00945		22. Name and Address of Facility	
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	Immediate Cause (Final disease or condition resulting in death)		a. <b>ELECTROMECHANICAL DISSOCIATION</b>					Approximate Interval Between Onset and Death <b>1 hr</b>
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>PULMONARY EDEMA</b>					<b>1 hr</b>
			c. <b>COMPLETE HEART BLOCK</b>					<b>2 DAYS.</b>
		d. <b>UNDERLYING CONDUCTION DISEASE</b>					<b>YRS.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSIVE CARDIOVASCULAR DISEASE, CHRONIC RENAL FAILURE.</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>G. Srinivasan, MD</b>		29c. License number <b>D-46345</b>		29d. Date signed (Month, Day, Year) <b>9/7/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gopalakrishnan Srinivasan, M.D. 3600 Leonardtown Road, Suite 103 Waldorf, Maryland 20601</b>								
31. Date filed (Month, Day, Year) <b>SEP 11 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 30133

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Emery Buddy Aliff, Jr.</b>				2. Date of Death Month Day Year <b>September 8, 2000</b>		3. Time of Death <b>3:15AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>8835 Dubois Road</b>				4b. City, Town, or Location of Death <b>Charlotte Hall</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>232-46-1434</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 12, 1932</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>Charlotte Hall</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>8835 Dubois Road</b>		10f. Zip Code <b>20622</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1951-1971</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Law Enforcement</b>		16b. Kind of Business/Industry <b>Police</b>				
17. Father's Name (First, Middle, Last) <b>Emery Buddy Aliff, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nell Norma Davis</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Brenda Aliff, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8835 Dubois Road, Charlotte Hall,</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		Date <b>9/21/00</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>		
21. Signature of Funeral Service Licensee <i>Reginald F. [Signature]</i>				22. Name and Address of Facility <b>Sterling Funeral Service</b> <b>1601 Kenilworth Avenue, Washington, DC 20019</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Cardiopulmonary Failure</b> Due to (or as a consequence of): b. <b>Coronary Heart Failure</b> Due to (or as a consequence of): c. <b>Cardiomyopathy</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>hrs.</b> <b>months</b> <b>yr.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D 06419</b>		29d. Date signed (Month, Day, Year) <b>9-11-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES JARBOE</b> <b>24035 THREE NOTCH ROAD, HOLLYWOOD, MARYLAND 20636</b>								
31. Date filed (Month, Day, Year) <b>SEP 12 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1978

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30134

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JANET MORRIS BOULDEN

2. Date of Death

September 12, 2000 2330

3. Time of Death

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

217-42-6153

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

12/24/1933

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

104 Payne Avenue

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Walter Daniel Morris

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Amanda Lank

19a. Informant's Name/Relationship (Type, Print)

Debbie Outten (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4743 Fleming Mill Rd., Pocomoke City, MD 21851

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

9/13/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

Michael A. Dean

22. Name and Address of Facility

Holloway Melson Funeral Home, P.A.

103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic small cell lung Ca

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hr

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Michael A. Dean

29c. License number

D20507

29d. Date signed (Month, Day, Year)

9/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph N. GRASSO 145 E. CARROLL ST SALISBURY MD

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Janet Boulden SS# 217426153  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30135

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wilson Poole Baker</b>				2. Date of Death Month <b>September</b> Day <b>4</b> Year <b>2000</b>		3. Time of Death <b>2315</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>216-09-6597</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 30, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Snow Hill</b>	
Usual Residence of Decedent								
10a. State <b>MD</b>			10b. County <b>Worcester</b>			10c. City, Town or Location <b>Snow Hill</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>215 West Martin St.,</b>			10f. Zip Code <b>21863</b>		
10g. Citizen of What Country? <b>US</b>			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>			16b. Kind of Business/Industry <b>Auto</b>			17. Father's Name (First, Middle, Last) <b>John C. Baker</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Juckett</b>			19a. Informant's Name/Relationship (Type, Print) <b>Gladys Baker (wife)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>215 West Martin St., Snow Hill, Md. 21863</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Christian Church Cem.</b>			20c. Location - City or Town, State <b>9-9-00 Snow Hill, MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>			22. Name and Address of Facility <b>The Burbage Funeral Home 208 W. Federal St., Snow Hill, Md. 21863</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)								
a. <b>Pneumonia</b> Due to (or as a consequence of):								
b. <b>Lung Cancer</b> Due to (or as a consequence of):								
c. <b>Renal Failure</b> Due to (or as a consequence of):								
d.								
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury <b>M</b>								
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> <b>MD</b>								
29c. License number <b>047094</b>								
29d. Date signed (Month, Day, Year) <b>9/6/00</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NATESAN 106 MILFORD STREET SALISBURY MD 21804</b>								
31. Date filed (Month, Day, Year) <b>SEP 08 2000</b>								
32. Registrar's Signature <i>[Signature]</i>								

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 30136

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY LORETTA WILLS BRISCOE

2. Date of Death

September 12, 2000 07:30AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9665 Doc's Place

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

5. Social Security Number

220-16-7225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

DEC. 2, 1919

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9665 DOC'S PLACE

10f. Zip Code

20646

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKER

17. Father's Name (First, Middle, Last)

WILLIAM HENRY WILLS

18. Mother's Name (First, Middle, Maiden Surname)

MATILDA JANE BURCH WILLS

19a. Informant's Name/Relationship (Type, Print)

MARY JANE SHORT / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8875 BRIDGETT LANE LA PLATA, MARYLAND 20646

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MD VETERAN CEMETERY

Date

9/19/00

20c. Location - City or Town, State

CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee

LYDIA C. THORNTON JOHNSON M00583

22. Name and Address of Facility

THORNTON FUNERAL HOME, P.A.  
3439 LIVINGSTON ROAD INDIAN HEAD, MD 2064023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure-End Stage

Due to (or as a consequence of):

b. Coronary Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending  
Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

A. M. Alikhani MD

29c. License number

D46046

29d. Date signed (Month, Day, Year)

9/12/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Amir Alikhani, MD., P.O. Box 1890, La Plata, MD 20646

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 24a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





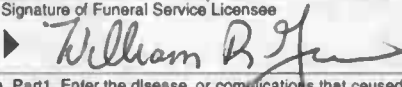
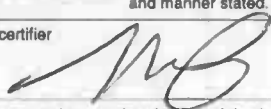
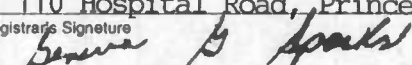
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30137

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAWRENCE WILLIAM BOND, JR.</b>				2. Date of Death Month <b>Sept.</b> Day <b>05</b> Year <b>2000</b>		3. Time of Death <b>19:27</b>	
	4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>579-50-1970</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>04-06-1938</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>West Virginia</b>					
10a. State <b>MD</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Lusby</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>50 Appeal Lane, Apt. 219</b>				10f. Zip Code <b>20657</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1956-62</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Service Technician</b>		16b. Kind of Business/Industry <b>Appliance</b>		
17. Father's Name (First, Middle, Last) <b>Lawrence William Bond, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nancy McClung</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sherry L. Blank/exwife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>209 5th St., Lothian, MD 20711</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>		Date <b>9-8-00</b>		20c. Location - City or Town, State <b>Cheltenham, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rausch Funeral Home, P.A. Owings, MD 20736</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ventricular Fibrillation</b> Due to (or as a consequence of): <b>b. End-Stage Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D33123</b>		29d. Date signed (Month, Day, Year) <b>9-7-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jonathan Lowenthal, M.D. 110 Hospital Road, Prince Frederick, MD 20678</b>								
31. Date filed (Month, Day, Year) <b>SEP 08 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Patricia Ann Brown

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30138

amend item 23a,27, per me G788 10/2/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Ann Brown</b>				2. Date of Death Month <b>August</b> Day <b>30</b> Year <b>2000</b>				3. Time of Death <b>08:30 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>3214 Sunrise Drive</b>				4b. City, Town, or Location of Death <b>Jefferson</b>				4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>158-44-5627</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 20 1952</b>		9. Birthplace (State or Foreign Country) <b>Oregon</b>		
	10a. State <b>MD</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Jefferson</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <b>3214 Sunrise Drive</b>		10f. Zip Code <b>21755</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b> <b>1 yr.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Homemaker</b>							
17. Father's Name (First, Middle, Last) <b>Ronnie Fable Sellers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Agnes Fandler</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Michael J. Brown, Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3214 Sunrise Drive, Jefferson, MD 21755</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hagerstown Crematory</b>		Date <b>9/4/00</b>		20c. Location - City or Town, State <b>Hagerstown, MD</b>					
21. Signature of Funeral Service Licensee <b>Barbara A. Williams, Owner</b>		22. Name and Address of Facility <b>John T. Williams Funeral Home 100 Petersville Road, Brunswick, MD 21716</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		a. <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
		b. Due to (or as a consequence of):									
		c. Due to (or as a consequence of):									
		d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
		28a. Place of Injury - At home, term, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Michael J. Brown</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>August 31, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John T. Williams, MD</b>		31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature <b>B. Spence</b>							
State Registrar											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30139

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clinton Arthur Bonney</b>				2. Date of Death Month <b>Aug.</b> Day <b>30</b> , Year <b>2000</b>		3. Time of Death <b>2:20 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Homewood at Crumland Farms</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>040-01-8901</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth Month <b>Aug.</b> Day <b>23</b> , Year <b>1914</b>		
	9. Birthplace (State or Foreign Country) <b>Conn.</b>		10a. State <b>Fla.</b>		10b. County <b>Volusia</b>		10c. City, Town or Location <b>Glenwood</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>Depot St.</b>		10f. Zip Code <b>32720</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>tool and die maker</b>		16b. Kind of Business/Industry <b>aerospace</b>					
17. Father's Name (First, Middle, Last) <b>Unknown Bonney</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Johnson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Alberta M. Bonney (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4701 Willow Rd., Frederick, MD. 21702</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory</b>		Date <b>8/30</b>		20c. Location - City or Town, State <b>Smithsburg, MD.</b>			
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Donald B. Thompson Funeral Home</b> <b>31 E. Main St., Middletown, MD. 21769</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>ATHEROSCLEROTIC CORONARY VASCULAR DISEASE</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>10 YRS</b>		b. <b>CHRONIC BRONCHITIS</b> Due to (or as a consequence of):		c. Due to (or as a consequence of):	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D47611</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 31, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael W. Warr MD 1475 TANKY AVE #204 FREDERICK MD 21702</b>		31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30140

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SISTER HELEN BURKE</b>				2. Date of Death Month Day Year <b>SEPT. 9, 2000</b>		3. Time of Death <b>6:45 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>ST. VINCENT CARE CENTER</b>				4b. City, Town, or Location of Death <b>EMMITSBURG</b>		4c. County of Death <b>FREDERICK</b>		
Funeral Director	5. Social Security Number <b>215-54-2887</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 15, 1921</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>FREDERICK</b>	10c. City, Town or Location <b>EMMITSBURG</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>335 S. SETON AVE.</b>			10f. Zip Code <b>21727</b>		10g. Citizen of What Country? <b>U. S. A.</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SCHOOL TEACHER</b>		16b. Kind of Business/Industry <b>RELIGIOUS COMMUNITY DAUGHTER OF CHARITY</b>				
	17. Father's Name (First, Middle, Last) <b>RICHARD J. BURKE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>KATHERINE KELLY</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>SISTER CAMILLA HARANT/SUPERIOR</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>333 S. SETON AVE., EMMITSBURG, MD. 21727</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. JOSEPH'S P.H.</b>		20c. Location - City or Town, State <b>EMMITSBURG, MD. 21727</b>		20d. Date <b>9/12/2000</b>		
	21. Signature of Funeral Service Licensee <b>John M. Skiles</b>				22. Name and Address of Facility <b>SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727</b>				
	23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Probable Acute Myocardial Infarction 30m</b> <b>Atherosclerotic and Valvular Heart Disease 10 yrs</b>								
	23b. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Hypertension</b> <b>Rheumatoid Arthritis</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Alan Carroll</b>		29c. License number <b>018705</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 9, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALAN CARROLL, M.D., 310 S. SETON AVE., EMMITSBURG, MD. 21727</b>									
31. Date filed (Month, Day, Year) <b>SEP 11 2000</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



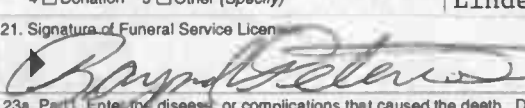
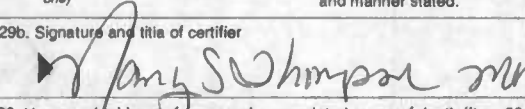
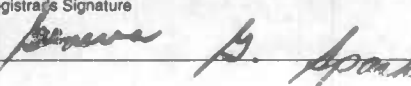
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30141

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alice M. Bowins</b>				2. Date of Death Month <b>Sept.</b> Day <b>8</b> Year <b>2000</b>		3. Time of Death <b>7:30 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>College View Center</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>218-30-8750</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 9, 1920</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>800 Motter Ave.</b>				10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>		
17. Father's Name (First, Middle, Last) <b>Harry Snowden</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Bowie</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Delores Harris / daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 86 / Libertytown, Maryland 21762</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Linden Hills Cemetery</b>		Date <b>9-11-00</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>		
21. Signature of Funeral Service Licen 				22. Name and Address of Facility <b>Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. metastatic colon cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. dementic</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>ID 0055995</b>		29d. Date signed (Month, Day, Year) <b>09/08/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Nancy S. Thompson, MD 172 Thomas Johnson Drive Suite 202 Frederick MD 21702</b>								
31. Date filed (Month, Day, Year) <b>SEP 11 2000</b>				32. Registrar's Signature 				

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30142

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Alison Bateman, Sr.				2. Date of Death Month Day Year August 31, 2000		3. Time of Death 11:30 A.M.	
	4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 228-22-4330		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Apr. 8, 1930	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Calvert		10c. City, Town or Location Lusby			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 12131 Bonanza Trail				10f. Zip Code 20657		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Engineer		16b. Kind of Business/Industry Construction		
17. Father's Name (First, Middle, Last) Arthur R. Bateman					18. Mother's Name (First, Middle, Maiden Surname) Grace Greenwood Wright			
19a. Informant's Name/Relationship (Type, Print) Lisa Buchanan/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5712 S. 3rd St. Arlington, VA 22204			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 9/1/00		20c. Location - City or Town, State Alexandria, VA	
21. Signature of Funeral Service Licensee Blodge A. Sewell					22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prostate cancer Due to (or as a consequence of): Metastases to bones Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic lung disease Due to (or as a consequence of): Liver failure								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Julia A. Haller					29c. License number D32600		29d. Date signed (Month, Day, Year) 8/31/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J.A. Haller 600 N. Wolfe St. Balto 21287								
31. Date filed (Month, Day, Year) SEP 05 2000			32. Registrar's Signature B. A. Smith					





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State of Maryland / Department of Health and Mental Hygiene

00 30143

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lydia S. Bell				2. Date of Death Month Day Year August 28, 2000				3. Time of Death 2:50 P.M.	
	4a. Facility Name (If not institution, give street and number) 220 Mason Road				4b. City, Town, or Location of Death Prince Frederick				4c. County of Death Calvert	
Funeral Director	5. Social Security Number 214-30-1117		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 100 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Nov. 27, 1899		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Calvert		10c. City, Town or Location Prince Frederick	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 220 Mason Road		10f. Zip Code 20678		10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic	
	16b. Kind of Business/Industry Someone Else's Home		17. Father's Name (First, Middle, Last) John Mason		18. Mother's Name (First, Middle, Maiden Surname) Annie Smallwood		19a. Informant's Name/Relationship (Type, Print) Lydia Brooks/Granddaughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 Mason Road Prince Frederick, MD 20678	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Western Cemetery		Date 9/1/00		20c. Location - City or Town, State Prince Frederick, MD		21. Signature of Funeral Service Licensee Dorothy A. Sewell	
	22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. End stage CHF Due to (or as a consequence of): b. A Fib Due to (or as a consequence of): c. Dementia Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Dore		29c. License number D 50290		29d. Date signed (Month, Day, Year) 8-30-00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dhiren Shah, M.D. Prince Frederick, MD 20678	
	31. Date filed (Month, Day, Year) AUG 30 2000		32. Registrar's Signature B		33. Registrar's Signature B		34. Registrar's Signature B		35. Registrar's Signature B	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



2

[illegible]

23 JUL 1972

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30144

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Louise Burton		2. Date of Death Month Day Year 08 30 2000		3. Time of Death 11:45 AM
	4a. Facility Name (If not institution, give street and number) SOLOMONS NURSING CENTER		4b. City, Town, or Location of Death DOWELL		4c. County of Death CALVERT
Funeral Director	5. Social Security Number 217-34-0528	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) Mar. 13, 1913		9. Birthplace (State or Foreign Country) West Virginia		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State Maryland		10b. County Calvert
	10c. City, Town or Location St. Leonard		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 4541 Kings Road		10f. Zip Code 20685		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary
	16b. Kind of Business/Industry Private Industry		17. Father's Name (First, Middle, Last) Abner Phillips		18. Mother's Name (First, Middle, Maiden Surname) Ethel Conrad
	19a. Informant's Name/Relationship (Type, Print) Nancy Stortzum/Niece		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4541 Kings Road St. Leonard, MD 20685		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, VA
	21. Signature of Funeral Service Licensee Bladys G. Sewell		22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. H/O Bladder ca Due to (or as a consequence of): b. H/O abd aortic aneurysm Due to (or as a consequence of): c. A FL/rupture Due to (or as a consequence of): d. CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. UTI HTN		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Bladys G. Sewell		29c. License number D 50290		29d. Date signed (Month, Day, Year) 8-30-00	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dhiren Shah, M.D. Prince Frederick, MD 20678					
31. Date filed (Month, Day, Year) AUG 30 2000		32. Registrar's Signature B. [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1992

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30145

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS E CLEMENTS			2. Date of Death Month Day Year September 12, 2000		3. Time of Death 4:00 PM	
	4a. Facility Name (If not institution, give street and number) 111 Eighth Street			4b. City, Town, or Location of Death Pocomoke City		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 021-22-9876	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 21, 1923	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County Worcester	10c. City, Town or Location Pocomoke City		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 111 Eighth Street		10f. Zip Code 21851		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1940-1970		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) ---		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aviation		16b. Kind of Business/Industry U.S. Military		
	17. Father's Name (First, Middle, Last) John Lloyd Clements			18. Mother's Name (First, Middle, Maiden Surname) Mary Sterling			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Paul Clements/Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 Hayward Ave., Fruitland, MD 21826			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion U. Methodist Cemetery		Date 9/18/00		20c. Location - City or Town, State Gloucester, VA
	21. Signature of Funeral Service Licensee <i>Michael A. Dean</i> MD1129			22. Name and Address of Facility Holloway Melson Funeral Home 103 Linden Ave., Pocomoke City, MD 21851			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic Lung Cancer</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>[Signature]</i> M.D.			29c. License number 030690		29d. Date signed (Month, Day, Year) Sept. 13, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>James E. Martin, M.D., 145 E. Carroll St., Salisbury, MD</i>						
31. Date filed (Month, Day, Year) SEP 14 2000			32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 30146

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joyce Lee Cavey</b>				2. Date of Death Month Day Year <b>Sept. 8, 2000</b>		3. Time of Death <b>07:12am</b>		
	4a. Facility Name (If not institution, give street and number) <b>321 City View Terrace</b>				4b. City, Town, or Location of Death <b>Cumberland</b>		4c. County of Death <b>Allegany</b>		
Funeral Director	5. Social Security Number <b>220-26-9369</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 27, 1930</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cumberland</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>321 City View Terrace</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>transportation dept</b>		16b. Kind of Business/Industry <b>U.S. Government</b>			
17. Father's Name (First, Middle, Last) <b>Robert Lee Meyers</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha (Webb)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Marna Sue Cavey</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Blackiston Avenue; Cumberland MD 21502</b>					
20a. Manner of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Lutheran Cem</b>		20c. Location - City or Town, State <b>9/11/ Cumberland, MD</b>			
21. Signature of Funeral Service Licensee <b>James F Scarpelli</b>				22. Name and Address of Facility <b>Scarpelli Funeral Home, P.A. Cumberland, MD 21502</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC SQUAMOUS CELL CA</b> Due to (or as a consequence of): <b>LUNG</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>2/2000</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how Injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>Jan MD</b>				29c. License number <b>D23371</b>		29d. Date signed (Month, Day, Year) <b>Sept. 8, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Qamar Zaman, M.D.; 625 Kent Avenue; Cumberland, MD 21502</b>									
31. Date filed (Month, Day, Year) <b>SEP 08 2000</b>		32. Registrar's Signature <b>Sparks</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 30147

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERTA CEFARATTI

2. Date of Death

Sept.

Day

05

Year

2000

3. Time of Death

10:15 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6705 Duck Lane

4b. City, Town, or Location of Death

Tracy's Landing

4c. County of Death

Anne Arundel

5. Social Security Number

215-44-5044

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

02-09-1947

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Tracy's Landing

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6705 Duck Lane

10f. Zip Code

20779

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Robert

Talkington

18. Mother's Name (First, Middle, Maiden Surname)

Charlotte

Moneymaker

19a. Informant's Name/Relationship (Type, Print)

Michael U. Cefaratti / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10 a-f

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Southern Memorial Gardens 9-8-00

Date

20c. Location - City or Town, State

Dunkirk, MD

21. Signature of Funeral Service Licensee

William R. H.

22. Name and Address of Facility

Rausch Funeral Home, P.A. Owings, MD 20736

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Liver Cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Catherine I. Brough

29c. License number

D45235

29d. Date signed (Month, Day, Year)

9/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10845 Town Center Blvd #203, Dunkirk, MD 20754

31. Date filed (Month, Day, Year)

SEP 08 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit data.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

22-10-1962

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30148

Amended Item 23a, 27 per MEOG 788 10/12/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph N. Creek</b>				2. Date of Death Month <b>SEPTEMBER</b> Day <b>08</b> Year <b>2000</b>				3. Time of Death <b>10:11 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>600 LARGO ROAD</b>				4b. City, Town, or Location of Death <b>LARGO</b>				4c. County of Death <b>PRINCE GEORGE'S</b>	
Funeral Director	5. Social Security Number <b>213-36-2171</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth (Month, Day, Year) <b>Apr. 22, 1940</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Owings</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1053 E. Chesapeake Beach Rd.</b>		10f. Zip Code <b>20736</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Construction</b>		17. Father's Name (First, Middle, Last) <b>Nicholas Creek</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hilda Wills</b>		19a. Informant's Name/Relationship (Type, Print) <b>Keith Creek/Son</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3610 Halloway North Upper Marlboro, MD 20772</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wards UM Church Cemetery</b>		20c. Location - City or Town, State <b>9/14/00 Chesapeake Beach, MD</b>		21. Signature of Funeral Service Licensee <b>Blaise A. Sewell</b>		
22. Name and Address of Facility <b>Sewell Funeral Home</b> <b>1451 Dares Beach Rd. Prince Frederick, MD 20678</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARDIAC ARRHYTHMIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>MYOCARDIAL (INTERSTITIAL) FIBROSIS</b>		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>J. M. Titus</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 09, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>		
31. Date filed (Month, Day, Year) <b>SEP 12 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		State Registrar		Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.		



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State of Maryland / Department of Health and Mental Hygiene

00 30149

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BETTY JANE CRAWFORD</b>				2. Date of Death Month Day Year <b>SEPTEMBER 9, 2000</b>				3. Time of Death <b>1:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>				4c. County of Death <b>Frederick</b>		
Funeral Director	5. Social Security Number <b>217-10-0169</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 17, 1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Walkersville</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>200 Chapel Court</b>		10f. Zip Code <b>21793</b>		10g. Citizen of What Country? <b>United States</b>							
11. Marital Status <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Proprietor</b>		16b. Kind of Business/Industry <b>Dry Cleaners</b>							
17. Father's Name (First, Middle, Last) <b>William A. Miller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Addie Koehler</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Steven Crawford / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>57 Main St. / Walkersville, MD 21793</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery</b>		20c. Location - City or Town, State <b>9-13-00 Frederick, Maryland</b>					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Stauffer Funeral Home</b> <b>40 Fulton Ave. / Walkersville, Maryland 21793</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>End stage COPD</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>7-10 yrs.</b>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Osteoporosis, Hypothyroid</b> <b>Cervical cancer, 1983</b>				23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown							
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No				24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No							
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <b>2</b> No		28c. Describe how injury occurred	
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>021944</b>		29d. Date signed (Month, Day, Year) <b>9/9/00</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James S. Grissom, MD / 300 W. Ninth St. / Frederick, Maryland 21701</b>											
31. Date filed (Month, Day, Year) <b>SEP 11 2000</b>				32. Registrar's Signature 							

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State of Maryland / Department of Health and Mental Hygiene

00 30150

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jack Lee Culler				2. Date of Death Month Day Year September 7, 2000		3. Time of Death 4:50 PM	
	4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 215-36-6856	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 65 Yrs.	8. Date of Birth (Month, Day, Year) Jan. 28, 1935	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Frederick	10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 234 East Third Street		10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Foreman		16b. Kind of Business/Industry Gas Company			
	17. Father's Name (First, Middle, Last) Clyde Henry Culler				18. Mother's Name (First, Middle, Maiden Surname) Lena Catherine Miller			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Cindy D. Culler, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 234 East Third St., Frederick, Maryland 21701			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Saint Lukes Cemetery, Sept. 11, 2000		20c. Location - City or Town, State Feagaville, Maryland			
	21. Signature of Funeral Service Licensee Richard E. Gray M00255		22. Name and Address of Facility Keeney and Basford PA Funeral Home 106 East Church St., Frederick, Md. 21701					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death Months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier M. Tolino MD/M. Tolino				29c. License number MD 51610		29d. Date signed (Month, Day, Year) 9-8-00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 1475 Tancy Ave Suite 204 Frederick MD 21702								
31. Date filed (Month, Day, Year) SEP 11 2000		32. Registrar's Signature B. [Signature]						

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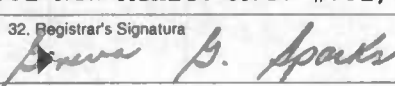
State of Maryland / Department of Health and Mental Hygiene

00 30151

## Certificate of Death

Reg. No.

amend item 1 per phys. G788 10/3/00 yf

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SELMA ANNE CHODOFF</b>				2. Date of Death Month <b>September</b> Day <b>5</b> Year <b>2000</b>		3. Time of Death <b>12:20</b>	
	4a. Facility Name (If not institution, give street and number) <b>4820 Dorset Ave.</b>				4b. City, Town, or Location of Death <b>Chevy Chase</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>157-01-3210</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Dec 22, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>PA</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>4820 Dorset Ave.</b>				10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>United States</b>	
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Actress</b>		16b. Kind of Business/Industry <b>Theater</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Samuel Blum</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Blank</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mark Chodoff /Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>498 Antlers Dr., Rochester, NY 14618</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Data <b>Sep 6 2000</b>		20c. Location - City or Town, State <b>Beltsville, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Rapp Funeral &amp; Cremation Services 933 Gist Avenue Silver Spring, MD</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> <b>b. Amyloidosis</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aortic Valve Disease</b>							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28e. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29d. Date signed (Month, Day, Year) <b>9-6-00</b>
	29b. Signature and title of certifier  <b>Mary Restifo M.D.</b>							
To Be Completed by Physician/Medical Examiner	29c. License number <b>DC6165</b>							29d. Date signed (Month, Day, Year) <b>9-6-00</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mary Restifo M.D. 3301 New Mexico Ave. #331, Washington, DC 20016</b>							
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>SEP 07 2000</b>							32. Registrar's Signature 
	31. Data filed (Month, Day, Year) <b>SEP 07 2000</b>							

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amend item 25, 27, 28a,b,c,d,e,f per Reg. G788 10/5/00 of State of Maryland / Department of Health and Mental Hygiene 00 30152  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edith K. Cartin</b>				2. Date of Death Month <b>August</b> Day <b>25<sup>th</sup></b> Year <b>00</b>		3. Time of Death <b>7:45 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>Carroll Lutheran Village Nursing Home</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll</b>			
Funeral Director	5. Social Security Number <b>216-10-2675</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 7, 1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Westminster</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>201 St. Mark Way #417</b>				10f. Zip Code <b>21158</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Payroll Supervisor</b>			16b. Kind of Business/Industry <b>Finance</b>			
17. Father's Name (First, Middle, Last) <b>David Henry Kelley</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Annie Lee Holbrook</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Buck Kelley (Nephew)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8747 Old Harford Rd., Baltimore, MD 21234</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Paran Cemetery</b>		Data <b>8/28/00</b>		20c. Location - City or Town, State <b>Holbrook, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Brian A. Haight</b>				22. Name and Address of Facility <b>HAIGHT FUNERAL HOME &amp; CHAPEL, P.A. (Box 195) Sykesville, MD 21784 (410)-795-1400</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pulmonary Embolism</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>Same day</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Compression Fracture</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>8/13/00</b>		28b. Time of Injury <b>unknown</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject fell in bedroom at home.</b>		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>apartment</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>201 St. Mark Way, #417 Westminster, Maryland</b>						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>[Signature]</b>					29c. License number <b>D37944</b>	
29d. Date signed (Month, Day, Year) <b>Aug. 25<sup>th</sup> 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Alexander Bogdanovich 205 St. Mark Way, Westminster, MD 21157</b>						
31. Date filed (Month, Day, Year) <b>AUG 29 2000</b>				32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30153

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **CALVIN O. DILTZ** 2. Date of Death Month **9** Day **10** Year **2000** 3. Time of Death **3:15 AM**

4a. Facility Name (If not institution, give street and number) **11647 Beauchamp RD** 4b. City, Town, or Location of Death **Berlin** 4c. County of Death **Worcester**

Funeral  
Director

5. Social Security Number **191-24-6785** 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) **71** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **10/23/1928** 9. Birthplace (State or Foreign Country) **PA**

Usual Residence of Decedent

10a. State **MD** 10b. County **Worcester** 10c. City, Town or Location **Berlin** 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number **11647 Beauchamp RD** 10f. Zip Code **21811** 10g. Citizen of What Country? **USA**

11. Marital Status ☐ Never Married ☐ Married ☐ Widowed ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **white**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **4** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Engineer** 16b. Kind of Business/Industry **U.S. Government**

17. Father's Name (First, Middle, Last) **Buss Diltz** 18. Mother's Name (First, Middle, Maiden Surname) **Adda Gordner**

19a. Informant's Name/Relationship (Type, Print) **Kenneth Diltz** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **410 Kunkle Lane Mechanicsburg, PA 17050**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Gordner's Cemetery** Date **9/14/00** 20c. Location - City or Town, State **Unityville, PA**

21. Signature of Funeral Service Licensee **[Signature]** 22. Name and Address of Facility **Burbage Funeral Home**  
**108 William St. Berlin, MD 21811**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Metastatic Esophageal Carcinoma** Approximate Interval Between Onset and Death **6 years**  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No 26. Place of Death (Check only one) Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending Investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier **[Signature]** 29c. License number **D46257** 29d. Date signed (Month, Day, Year) **9/11/00**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **9714 Heathway Drive Berlin, MD 21811 Edwin Castaneda, MD**

State  
Registrar

31. Date filed (Month, Day, Year) **SEP 12 2000** 32. Registrar's Signature **[Signature]**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30154

Amended item #23a, 9/14/2000, E.T, WCHD

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM HENRY DIX</b>				2. Date of Death Month <b>SEPT.</b> Day <b>12,</b> Year <b>2000</b>		3. Time of Death <b>1:35 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>7101 DAFFODIL LANE</b>				4b. City, Town, or Location of Death <b>NEWARK</b>		4c. County of Death <b>WORCESTER</b>	
Funeral Director	5. Social Security Number <b>222-05-0398</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 14, 1915</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>NEWARK</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>7101 DAFFODIL LANE</b>				10f. Zip Code <b>21841</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MAINTENANCE</b>		16b. Kind of Business/Industry <b>HOUSING</b>		
17. Father's Name (First, Middle, Last) <b>BURLEIGH H. DIX</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BESSIE LECATA LITTLETON</b>				
19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA KLINGER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>203 YOAKUM PKW., #407, ALEXANDRIA, VA. 22304</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKSLEY CEMETERY</b>		Data <b>9/15/2000</b>		20c. Location - City or Town, State <b>PARKSLEY, VA</b>		
21. Signature of Funeral Service Licensee  <b>CARL THORNTON</b>				22. Name and Address of Facility <b>THORNTON FUNERAL HOME</b> <b>24183 CHADBOURNE ST. - PARKSLEY, VA 23421</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Laryngeal</b> <b>LARYNGEAL CARCINOMA</b> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D02556</b>		29d. Date signed (Month/Day/Year) <b>9/14/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. G. SANTIANO, M.D. 100 8th St. Pocomoke, MD. 21851</b>								
31. Date filed (Month, Day, Year) <b>SEP 14 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30155

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THEODORE E. DIXON</b>				2. Date of Death Month <b>9</b> Day <b>8</b> Year <b>2000</b>		3. Time of Death <b>0325</b>	
	4e. Facility Name (If not institution, give street and number) <b>Atlantic General Hospital</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>203-05-2777</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9/1/1919</b>		9. Birthplace (State or Foreign Country) <b>PA</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>DE</b>	10b. County <b>New Castle</b>		10c. City, Town or Location <b>Wilmington</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1405 Marsh RD</b>				10f. Zip Code <b>19802</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Tinsmith</b>		16b. Kind of Business/Industry <b>Heating and Air</b>	
	17. Father's Name (First, Middle, Last) <b>Andrew Dixon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sophia Yedziniak</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary J. Dixon/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1405 Marsh RD Wilmington, DE 19802</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gracelawn Memorial Park</b>		Date <b>9/12/00</b>		20c. Location - City or Town, State <b>New Castle, DE</b>	
	21. Signature of Funeral Service Licensee <i>Burke Burke Nos 701</i>				22. Name and Address of Facility <b>Burbage Funeral Home 108 William St. Berlin, MD 21811</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>COPD</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							
	Approximate Interval Between Onset and Death <b>MANY YEARS</b>							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASCVD, RADIATION TREATMENT FOR THROAT CARCINOMA</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Dorothy C. Holzworth, M.D.</i>				29c. License number <b>D 06241</b>		29d. Date signed (Month, Day, Year) <b>09-08-00</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HALL, MD. 21863</b>							
31. Date filed (Month, Day, Year) <b>SEP 12 2000</b>		32. Registrar's Signature <i>B. Sparks</i>						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30156

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GLORIA JEAN DELAUTER</b>				2. Date of Death Month Day Year <b>August 31, 2000</b>		3. Time of Death <b>9:16 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>578-68-1558</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10-13-51</b>	
	9. Birthplace (State or Foreign Country) <b>D.C.</b>		10a. State <b>MD</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>5676 Pebble Drive</b>				10f. Zip Code <b>21703</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>Black</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2yrs.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse LPN</b>		16b. Kind of Business/Industry <b>Nursing Home</b>			
	17. Father's Name (First, Middle, Last) <b>Votie Dixon, Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edith Thomas</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>William DeLauter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5676 Pebble Dr. Frederick, MD 21703</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Memorial</b>		20c. Date <b>9-7-00</b>		20d. Location - City or Town, State <b>Frederick, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gary L. Rollins Funeral Home</b> <b>110 West South St. Frederick, MD 21701</b>			
	23a. Part I. Enter the illness or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>HYPERKALHEMIA</b> Due to (or as a consequence of): <b>ACUTE AND CHRONIC RENAL FAILURE</b> Due to (or as a consequence of): <b>SYSTEMIC LUPUS ERYTHEMATOSUS</b> Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>George I. Smith M.D. - VPHA</b>				29c. License number <b>D10587</b>		29d. Date signed (Month, Day, Year) <b>09/07/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GEORGE I. SMITH, M.D. - VICE PRES MDG AFFAIRS</b> <b>FREDERICK MEM HOSP</b> <b>FREDERICK, MD 21701</b>								
31. Date filed (Month, Day, Year) <b>SEP 08 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30157

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eleanor S. Dukes</b>		2. Date of Death Month Day Year <b>September 02 2000</b>		3. Time of Death <b>08:46</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>222-10-3810</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (in yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>10-23-1920</b>		9. Birthplace (State or Foreign Country) <b>DELAWARE</b>		
Usual Residence of Decedent					
10a. State <b>DELAWARE</b>		10b. County <b>SUSSEX</b>		10c. City, Town or Location <b>LAUREL</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>Rt. # 1, BOX 64</b>			10f. Zip Code <b>19956</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>		16b. Kind of Business/Industry <b>NONE</b>	
17. Father's Name (First, Middle, Last) <b>JESSE STEEN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>CLARA ELLIOTT</b>		
19a. Informant's Name/Relationship (Type, Print) <b>MARGARET HOLLOWAY / DAUGHTER</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. #1, BOX 64C, LAUREL, DE 19956</b>		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ODDFELLOWS CEMETERY</b>		20c. Location - City or Town, State <b>9-6-00 LAUREL, DELAWARE</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>MELSON FUNERAL SERVICES, LTD. 41 THATCHER ST., FRANKFORD, DE 19945</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>brain abscess</b>			Approximate Interval Between Onset and Death <b>8 days</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>Res-000</b>		29d. Date signed (Month, Day, Year) <b>September 02, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Wendy Ziai, Johns Hopkins Hospital 600 North Wolfe Street Baltimore MD 21287</b>					
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature 			





Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30158

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY PURNELL FOWLER

2. Date of Death

Month

Day

Year

3. Time of Death

12:15 PM

4a. Facility Name (If not institution, give street and number)

Center  
Brooke Grove Rehabilitation and Nursing

4b. City, Town, or Location of Death

Sandy Spring

4c. County of Death

Montgomery

5. Social Security Number

217-48-4768

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

7/11/1906

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Sandy Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1612 Hickory Knoll RD

10f. Zip Code

20860

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nursing

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

Wilmer Spence Purnell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Agnes Morris

19a. Informant's Name/Relationship (Type, Print)

Judy Reeser/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

43 Bramblewood Dr. Berlin, MD 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Paul's Episcopal

Date

9/7/00

20c. Location - City or Town, State

Berlin, MD

21. Signature of Funeral Service Licensee

Burbage

22. Name and Address of Facility

Burbage Funeral Home

108 William St. Berlin, MD 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PULMONARY EMBOLUS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MINUTES

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. DEEP VEIN THROMBOSIS.

Due to (or as a consequence of):

DAYS

c. FRACTURE RIGHT FEMUR.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. E. Howe

29c. License number

D33700

29d. Date signed (Month, Day, Year)

SEPTEMBER 4, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

TED E. HOWE, MD 7542 OVERLOOK DR. BOONSBORO, MD 21713

31. Date filed (Month, Day, Year)

SEP 08 2000

32. Registrar's Signature

B. Spahr

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

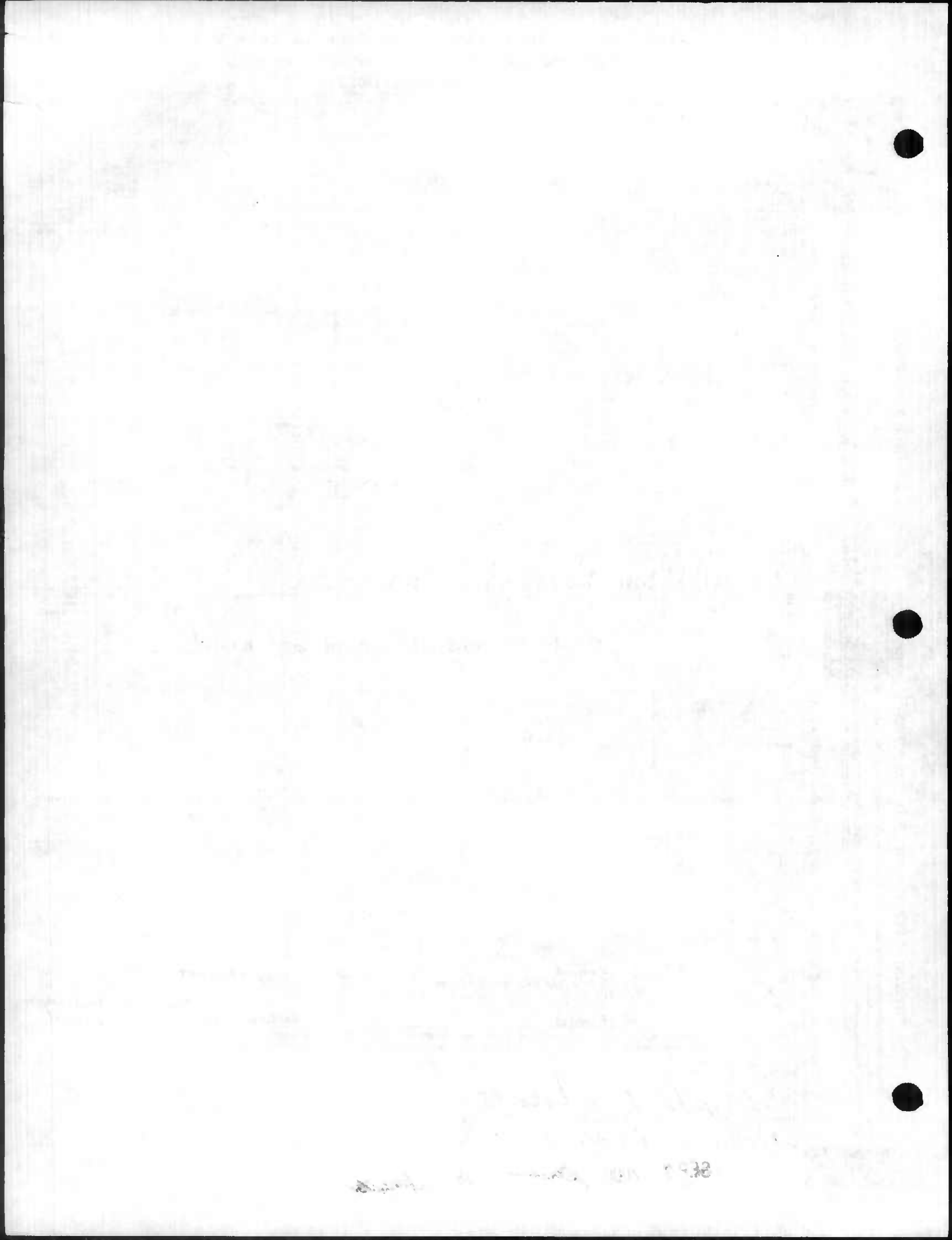
00 30159

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) David Paul Flottemesch				2. Date of Death Month Day Year SEPT. 4, 2000				3. Time of Death 0910 AM					
	4a. Facility Name (If not institution, give street and number) BRADSHAW ROAD AND PHILADELPHIA ROAD				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE					
Funeral Director	5. Social Security Number 213-96-6125		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 20 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) June 10, 1980		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent													
10a. State Maryland		10b. County Harford		10c. City, Town or Location Abingdon				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
10e. Street and Number 4309 Old Philadelphia Road				10f. Zip Code 21009				10g. Citizen of What Country? USA						
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student				16b. Kind of Business/Industry -----						
17. Father's Name (First, Middle, Last) Paul Joseph Flottemesch						18. Mother's Name (First, Middle, Maiden Surname) Barbara Lynn Flottemesch								
19a. Informant's Name/Relationship (Type, Print) Paul J. Flottemesch/Father						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4309 Old Philadelphia Road, Abingdon, MD 21009								
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Darlington Cemetery		Date 9-8-00		20c. Location - City or Town, State Darlington, MD						
21. Signature of Funeral Service Licensee <i>Holly McComas Pennington</i>						22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Contact gunshot wound of head Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
										24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) Found 9-4-2000		28b. Time of Injury unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject shot self				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Field				28f. Location (Street and Number or Rural Route Number, City or Town, State) Bradshaw / Philadelphia Baltimore County, Maryland						
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier <i>Stephen S. Radentz, M.D.</i>						29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) SEPT. 5, 2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201														
31. Date filed (Month, Day, Year) SEP 7 2000				32. Registrar's Signature <i>[Signature]</i>										

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30160

Amended items #28a-28f per doctor **Certificate of Death** FCHD, KS Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Joseph Roland Gamble, Jr.</b>		2. Date of Death Month <b>September</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>5:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>		4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>219-36-9361</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>58</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Sept. 26, 1941</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>					
Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number <b>20218 Halethorpe Lane</b>			10f. Zip Code <b>20874</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Fire Fighter</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>District of Columbia</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Roland Gamble, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Pierce</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Suzanne Christine Bennett - Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6930 Doublebrand Court, Frederick, Maryland 21703</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematorium</b>		20c. Location - City or Town, State <b>9/7/2000 Alexandria, Virginia</b>		
21. Signature of Funeral Service Licensee <b>Robert L. Williams</b>			22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ventricular fibrillation -&gt; asystole</b> Due to (or as a consequence of): <b>b. Acute MI</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>N/A.</b>						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DQA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>9/1/00</b>		28b. Time of Injury <b>10:00 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred <b>Heart</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Annapolis</b>						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <b>W. Gummerson</b>			29c. License number <b>00024336</b>		29d. Date signed (Month, Day, Year) <b>9/1/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R.S. Gummerson, MD, ANMC, Annapolis 21401</b>						
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature <b>B. Spar</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30161

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Naomi Ganey</b>				2. Date of Death Month Day Year <b>September 06, 2000</b>		3. Time of Death <b>12:49 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-12-1445</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>May 26, 1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>8624 Yellow Springs Road</b>				10f. Zip Code <b>21703</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse's Aide</b>			16b. Kind of Business/Industry <b>Health Care</b>	
17. Father's Name (First, Middle, Last) <b>Gurney Eugene Brashear</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ada Lenora Main</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Mr. John L. Ganey, Jr/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8624 Yellow Springs Road, Frederick, MD 21703</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pleasant Hill Cemetery Sep 11, 2000 Monrovia, Maryland</b>			20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>Keeney &amp; Basford</i> M00706				22. Name and Address of Facility <b>Keeney &amp; Basford P.A. Funeral Home</b> <b>106 East Church St, Frederick, MD 21701</b>				
23a. Part II. Enter in disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MULTIPLE INJURIES</b>								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>MULTIPLE INJURIES</b> Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>9/6/00</b>		28b. Time of Injury <b>850 A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>DRIVER OF CAR INVOLVED IN MOTOR VEHICLE COLLISION</b>
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HIGHWAY</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>RT. 144 EAST OF QUINN ORCHARD RD, FREDERICK, MD</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 07, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>SEP 11 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL



00-5070-021  
cm  
Minnie Good

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30162

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Minnie Mildred Good				2. Date of Death Month Day Year September 06, 2000				3. Time of Death 9:00 A.M.	
	4a. Facility Name (If not institution, give street and number) Route 144 East of Quinn Orchard Road				4b. City, Town, or Location of Death Frederick				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-38-7848		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) July 26, 1916		9. Birthplace (State or Foreign Country) West Virginia	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 6008 Quinn Orchard Road				10f. Zip Code 20704				10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Charles F. Hough				18. Mother's Name (First, Middle, Maiden Surname) Lucy Viands						
19a. Informant's Name/Relationship (Type, Print) Dorcas J. Main - Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6105C Quinn Road, Frederick, Maryland 21701						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Pleasant Hill Cemetery		20c. Date 9/9/00		20d. Location - City or Town, State Monrovia, Maryland				
21. Signature of Funeral Service Licensee Olin L. Molesworth				22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. MULTIPLE INJURIES Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 9/6/00		28b. Time of Injury 850 AM		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred PASSENGER OF CAR INVOLVED IN MOTOR VEHICLE COLLISION		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) HIGHWAY		28f. Location (Street and Number or Rural Route Number, City or Town, State) RT. 144 EAST OF QUINN ORCHARD RD, FREDERICK, MD								
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier Mary G. Ripple, M.D.				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) September 07, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) SEP 08 2000		32. Registrar's Signature B. Spore								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30163

Amended item#26 per doctor 09/14/2000

Certificate of Death FCHD, KS

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH VIRGINIA GRABLE</b>		2. Date of Death Month Day Year <b>Sept. 8, 2000</b>		3. Time of Death <b>4:05AM</b>
	4a. Facility Name (If not institution, give street and number) <b>10 King Avenue</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>
Funeral Director	5. Social Security Number <b>215-34-3408</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Sept. 10, 1928</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>7141 A Linganore Road</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ioma Smith</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Gale Smith (Daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 King Avenue, Frederick, Maryland 21701</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Utica Cemetery</b>		20c. Location - City or Town, State <b>9/11/00 Utica, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>ROBERT F. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Small cell lung Cancer</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cardiomyopathy</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> <del>6</del> Other (Specify) <b>Daughter's Residence</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>1475 TANEY AVE</b>		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>FILED MD 21702</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D26516</b>		29d. Date signed (Month, Day, Year) <b>SEPT 8 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Allen J. Galt 1475 TANEY AVE FILED MD 21702</b>					
31. Date filed (Month, Day, Year) <b>SEP 11 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Man

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30164

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edythe D. Gowin				2. Date of Death Month Day Year September 8, 2000		3. Time of Death 11:45 A.M.	
	4a. Facility Name (If not institution, give street and number) 2507 Penn Hill Road				4b. City, Town, or Location of Death Mt. Airy		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 099-03-5751	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 28, 1915		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Carroll		10c. City, Town or Location Mt. Airy		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 2507 Penn Hill Road				10f. Zip Code 21771		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting Clerk		16b. Kind of Business/Industry Telephone			
	17. Father's Name (First, Middle, Last) Joseph Depre				18. Mother's Name (First, Middle, Maiden Surname) Minnie H. Heinken			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) John G. Gowin / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2507 Penn Hill Road, Mt. Airy, Maryland 21771			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		Date Sept. 13, 2000		20c. Location - City or Town, State Brentwood, Maryland	
	21. Signature of Medical Examiner 		22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <u>Cancer of Colon</u> <span style="float: right;">~ 6 months</span></p> <p>b. <u>Renal cell cancer</u> <span style="float: right;">~ 6 months</span></p> <p>c. _____</p> <p>d. _____</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D 51705		29d. Date signed (Month, Day, Year) 9-11-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. PANSURIA, MD 49F Malcolm DR, Westminister, MD 21157								
State Registrar	31. Date filed (Month, Day, Year) SEP 12 2000		32. Registrar's Signature 					

ORIGINAL

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo Be Completed by  
Funeral DirectorTo Be Completed by  
Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30165

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ella Saathoff GADOW				2. Date of Death Month Day Year AUGUST 30 2000				3. Time of Death 15:55 PM		
	4a. Facility Name (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL				4b. City, Town, or Location of Death PRINCE FREDERICK				4c. County of Death CALVERT		
Funeral Director	5. Social Security Number 212 07 8508		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83		8. Date of Birth (Month, Day, Year) May 31, 1917		9. Birthplace (State or Foreign Country) Iowa		
	Usual Residence of Decedent										
10a. State MD		10b. County Calvert		10c. City, Town or Location Prince Frederick				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number 140 Calvert Towne Drive				10f. Zip Code 20678				10g. Citizen of What Country? USA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) homemaker				16b. Kind of Business/Industry own home			
17. Father's Name (First, Middle, Last) Frank Saathoff				18. Mother's Name (First, Middle, Maiden Surname) Hilka Jelden							
19a. Informant's Name/Relationship (Type, Print) Alfred B. Gadow (husb.)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10 above							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Southern Mem. Gardens		20c. Location - City or Town, State Dunkirk, MD					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736							
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>MULTIPLE INJURIES</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Arteriosclerotic Cardiovascular Disease</u>											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 8/30/00		28b. Time of Injury 1:46 P M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred PASSENGER INVOLVED IN MOTOR VEHICLE ACCIDENT PRINCE FREDERICK, MD	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 31, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TIMS, M.D. 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) SEP 01 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30166

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WILLIAM HOWARD HART, JR.				2. Date of Death Month Day Year SEPTEMBER 10 2000		3. Time of Death 5:26 PM
	4a. Facility Name (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				4b. City, Town, or Location of Death LANHAM		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 218-54-9299	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 31 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MAY 12, 1969	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County CHARLES	10c. City, Town or Location MARBURY			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number ROUTE #224, BOX 212			10f. Zip Code 20658		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11TH GRADE College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) INSTALLER		16b. Kind of Business/Industry WINDOW & DOOR CO.		
	17. Father's Name (First, Middle, Last) WILLIAM HOWARD HART, SR.				18. Mother's Name (First, Middle, Maiden Surname) CATHERINE OLIVE DUNNINGTON DAY		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CATHERINE DAY / MOTHER			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROUTE #224, BOX 212, MARBURY, MARYLAND 20658			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) ST. CHARLES CEMETERY		Data 9/16/00	20c. Location - City or Town, State GLYMONT, MARYLAND	
	21. Signature of Funeral Service Licensee Lydia C. Thornton Johnson		22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Approximate Interval Between Onset and Death 2-3 DAYS						
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SEIZURE DISORDER ACUTE PANCREATITIS					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier [Signature] MD		29c. License number D51083		29d. Date signed (Month, Day, Year) 9-12-00		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YISA YUSSUE MD 6712 VILLAGE PARK DRIVE GREENBELT, MD 20770						
31. Date filed (Month, Day, Year) SEP 14 2000		32. Registrar's Signature [Signature]					

ORIGINAL



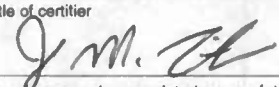
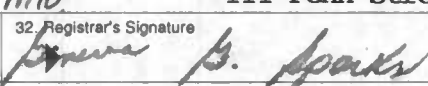
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30167

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Forrest Lee Henley, Jr.</b>				2. Date of Death Month Day Year <b>AUGUST 30 2000</b>		3. Time of Death <b>16:56 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>306 BRESLIN ROAD</b>			4b. City, Town, or Location of Death <b>JOPPA</b>		4c. County of Death <b>HARFORD</b>			
Funeral Director	5. Social Security Number <b>226-66-4160</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 30, 1951</b>			
	9. Birthplace (State or Foreign Country) <b>Virginia</b>								
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Joppa</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>306 Breslin Road</b>				10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>		16b. Kind of Business/Industry			
17. Father's Name (First, Middle, Last) <b>Forrest Lee Henley, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Marie Ruhl</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Forrest L. Henley, Sr.-Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>313 Avedon Court, Joppa, Maryland 21085</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Signal Hill Memorial Park</b>		Date <b>9/2/2000</b>		20c. Location - City or Town, State <b>Hanover, Virginia</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McConas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009</b>					
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. STAB Wound of chest and Cutting Wounds of NECK</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>8/30/00</b>		28b. Time of Injury (Hour, Minute) <b>3:08 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how Injury occurred <b>SUBJECT CUT AND STABBED SELF</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>306 BRESLIN ROAD JOPPA, MD</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 31, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TINS, MD 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>SEP 6 2000</b>		32. Registrar's Signature 							

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Reg. No.

00 30168

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Timothy Allen Hudson		2. Date of Death Month: SEP, Day: 15, Year: 2000		3. Time of Death 22:49 PM
	4a. Facility Name (If not institution, give street and number) 5021 TEMPLE HILL ROAD		4b. City, Town, or Location of Death TEMPLE HILLS		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 212-80-8719	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 38 Yrs.	8. Date of Birth (Month, Day, Year) Jun. 1, 1962	9. Birthplace (State or Foreign Country) Virginia
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County Prince George's	10c. City, Town or Location Temple Hills		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number 5021 Temple Hills Road		10f. Zip Code 20748		10g. Citizen of What Country? USA
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Toy's-R- Us		
	17. Father's Name (First, Middle, Last) Allen Russell Hudson		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Rose Mariast		
	19a. Informant's Name/Relationship (Type, Print) Elizabeth R. Hudson		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as Item#10		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State 09/16/00 Alexandria, Virginia
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Rd., Oxon Hill, Maryland 20745		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ALCOHOL AND NARCOTIC INTOXICATION Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was cause referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) SCENE			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 9/15/00		28b. Time of Injury unknown M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown			
28e. Location (Street and Number or Rural Route Number, City or Town, State) 5021 Temple Hills Rd., Temple Hills, MD		28f. Location (Street and Number or Rural Route Number, City or Town, State) 5021 Temple Hills Rd., Temple Hills, MD			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number OCME	
29d. Date signed (Month, Day, Year) SEPTEMBER 16, 2000		29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark A. Korow 111 Penn Street, Baltimore, Maryland 21201			
State Registrar	31. Date filed (Month, Day, Year) SEP 25 2000	32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30169

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HENRY WALTER HOCH</b>				2. Date of Death Month <b>September</b> Day <b>3</b> Year <b>2000</b>				3. Time of Death <b>1952</b>	
	4a. Facility Name (If not Institution, give street and number) <b>The Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Easton</b>				4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>213-10-8258</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT 10, 1919</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>EASTON</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>77 PARK LANE</b>				10f. Zip Code <b>21601</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MOLD MAKER</b>				16b. Kind of Business/Industry <b>GLASSWARE MANUFACTURING</b>		
17. Father's Name (First, Middle, Last) <b>HENRY E. HOCH</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>BERTHA HART</b>						
19a. Informant's Name/Relationship (Type, Print) <b>LILLIAN S. HOCH/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>77 PARK LANE EASTON, MD 21601</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD VETERANS CEMETERY</b>		Date <b>9-07-00</b>		20c. Location - City or Town, State <b>HURLOCK, MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i> <b>CKSP</b>				22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Adult Respiratory Distress</b> days Due to (or as a consequence of): <b>b. Massive Retroperitoneal Hemorrhage</b> 2 weeks Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Muscular dystrophy</b>										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D23066</b>			29d. Date signed (Month, Day, Year) <b>9/4/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STANLEY M. BYSSHE, JR M.D. 506 DUTCHMANS LANE EASTON, MD 21601</b>										
31. Date filed (Month, Day, Year) <b>SEP 05 2000</b>		32. Registrar's Signature <i>[Signature]</i>								

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30170

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irma Elaine HARRISON				2. Date of Death Month Day Year September 10, 2000				3. Time of Death 10:55 am			
	4a. Facility Name (If not institution, give street and number) Calvert County Nursing Center				4b. City, Town, or Location of Death Prince Frederick				4c. County of Death Calvert			
Funeral Director	5. Social Security Number 215 44 7965		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 76		8. Date of Birth (Month, Day, Year) June 15, 1924		9. Birthplace (State or Foreign Country) MD			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County Calvert		10c. City, Town or Location Owings				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 9925 Old Solomons Island Rd.				10f. Zip Code 20736		10g. Citizen of What Country? USA					
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) administrative assistant				16b. Kind of Business/Industry U.S. Postal Service			
	17. Father's Name (First, Middle, Last) Rufus Dolly Harrison				18. Mother's Name (First, Middle, Maiden Surname) Mary Elizabeth Moreland							
	19a. Informant's Name/Relationship (Type, Print) John Wm. Harrison (brother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 77, Owings, MD 20736							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Harmony UM Church Cem.		20c. Location - City or Town, State 9-13-00 Owings, MD					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Rausch Funeral Home, Owings, MD 20736							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Multi-Infarcts (emboli) to brain (Cerebrovascular Accidents) 3-5 yrs. Due to (or as a consequence of): b. Atrial Fibrillation 2-3 yrs. Due to (or as a consequence of): c. Arteriosclerotic Cardiovascular Disease years. Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Recurrent Urinary Tract Infections. Chronic Venous Insufficiency - legs											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
					28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	29b. Signature and title of certifier Gerald P. Steener MD				29c. License number D 17245				29d. Date signed (Month, Day, Year) 9-10-00			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gerald P. Steener, M.D., Calvert-Arundel Medical Center, 19 Chesapeake Beh Rd, Owings MD											
	31. Date filed (Month, Day, Year) SEP 11 2000				32. Registrar's Signature Benjamin B Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 30171

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Pamela Kay Hubinger				2. Date of Death Month Day Year Sept. 1 2000		3. Time of Death 5:45 p.m.	
	4a. Facility Name (If not institution, give street and number) 810-C Heather Ridge Drive				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 063-54-6700	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 26, 1959		9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent							
10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 810 C Heather Ridge Drive				10f. Zip Code 21702		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Customer Service		16b. Kind of Business/Industry Credit Card Company		
17. Father's Name (First, Middle, Last) Norman Lungstrom				18. Mother's Name (First, Middle, Maiden Surname) Patricia Paisted				
19a. Informant's Name/Relationship (Type, Print) Mark T. Hubinger / husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 C Heather Ridge Drive, Frederick, MD 21702				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maple Grove Cemetery		20c. Location - City or Town, State 9/6/00 Horseheads, New York		
21. Signature of Funeral Service Licensee Jaqueline L. Kern				22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Respiratory Failure</u> Due to (or as a consequence of): b. <u>metastatic breast CA</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 2 weeks 4 years								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Brain metastases</u>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]				29c. License number D14220		29d. Date signed (Month, Day, Year) Sept 2 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D G. [Signature] 501 W 17th St Frederick MD 21701								
31. Date filed (Month, Day, Year) SEP 05 2000				32. Registrar's Signature [Signature]				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30172

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Fred Johnson</b>		2. Date of Death Month <b>September</b> Day <b>6</b> Year <b>2000</b>		3. Time of Death <b>5:10 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>115 Pushaw Station Road</b>		4b. City, Town, or Location of Death <b>Sunderland</b>		4c. County of Death <b>Calvert</b>
Funeral Director	5. Social Security Number <b>577-24-2417</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>May 10, 1912</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Sunderland</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>115 Pushaw Station Road</b>			10f. Zip Code <b>20689</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Sawmill</b>	
17. Father's Name (First, Middle, Last) <b>William Johnson</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Whitfield</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Louise Morsell/Friend</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>115 Pushaw Station Rd. Sunderland, MD 20689</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Hope UM Church Cem.</b>		20c. Location - City or Town, State <b>9/11/00 Sunderland, MD</b>	
21. Signature of Funeral Service Licensee <b>Gladys G. Sewell</b>		22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Adenocarcinoma colon - recurrence &amp; Liver Metastases</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					Approximate Interval Between Onset and Death <b>6 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe Anemia - GI blood loss</b> <b>Diabetes mell. T2</b> <b>Severe Peripheral Vascular Disease.</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b></b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b></b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Gerald P. Sterner M.D.</b>		29c. License number <b>D 17245</b>		29d. Date signed (Month, Day, Year) <b>September 6, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gerald P. Sterner M.D.</b>		<b>19 Chesapeake Beach Road East Owings, Md. 20736</b>			
31. Date filed (Month, Day, Year) <b>SEP 07 2000</b>		32. Registrar's Signature <b>Gerald P. Sterner</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

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— *Journal of the American Medical Association*, 1997

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*[Faint handwritten notes at the bottom of the page]*

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State of Maryland / Department of Health and Mental Hygiene

00 30173

Amend #1,9/8/2000, per M.D., BMW, Montg. Co.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Kyle Thomas Jones</i>		2. Date of Death Month: <i>Sept.</i> Day: <i>6</i> Year: <i>2000</i>		3. Time of Death <i>17:55</i>
	4a. Facility Name (If not institution, give street and number) <i>10720 Windham St.</i>		4b. City, Town, or Location of Death <i>Silver Spring</i>		4c. County of Death <i>Montgomery</i>
Funeral Director	5. Social Security Number <i>578-04-0553</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>35</i> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.
	8. Date of Birth (Month, Day, Year) <i>Oct. 21, 1964</i>		9. Birthplace (State or Foreign Country) <i>D.C.</i>		
Usual Residence of Decedent					
10a. State <i>Md.</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Silver Spring</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10a. Street and Number <i>10720 Windham St.</i>			10f. Zip Code <i>20902</i>		10g. Citizen of What Country? <i>U. S. A.</i>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+)			16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Data Processor</i>		16b. Kind of Business/Industry <i>Computer Co.</i>
17. Father's Name (First, Middle, Last) <i>James Thomas Jones</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Peggy Ann Crew</i>		
19a. Informant's Name/Relationship (Type, Print) <i>James Thomas Jones, Father</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3721 Lacy Blvd, Falls Church, Va. 22041</i>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Lincoln Memorial Cem.</i>		20c. Location - City or Town, State <i>9/11/00 Suitland, Md.</i>	
21. Signature of Funeral Service Licensee <i>Bernard O. Ames</i>			22. Name and Address of Facility <i>Ames Funeral Home, Inc. 8914 Quarry Rd. Manassas, Va. 20110</i>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <i>Pneumonia (bacterial)</i>			Approximate Interval Between Onset and Death <i>4 d.</i>
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):			
		b. <i>Acquired immunodeficiency syndrome</i>			<i>8 yr.</i>
		Due to (or as a consequence of):			
		c. <i>Human immunodeficiency virus infection</i>			<i>16 yr.</i>
Due to (or as a consequence of):		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<i>Severe emphysema with giant bullae</i>					
<i>Malnutrition, wasting</i>					
<i>Treated chronic clinical depression</i>					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Katharine Waldmann, M.D.</i>		29c. License number <i>D008818</i>		29d. Date signed (Month, Day, Year) <i>Sept. 7, 2000</i>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Katharine Waldmann, MD, 2000 Dennis Ave. Silver Spring, MD 20902</i>					
31. Date filed (Month, Day, Year) <i>SEP 08 2000</i>		32. Registrar's Signature <i>B. Spahr</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30174

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Frederick Kirby</b>			2. Date of Death Month: <b>08</b> Day: <b>29</b> Year: <b>00</b>		3. Time of Death <b>6:15 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2246 Birch Road</b>			4b. City, Town, or Location of Death <b>Port Republic</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>578 05 9379</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 31 1910</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>						
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Port Republic</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2246 Birch Road</b>				10f. Zip Code <b>20676</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+) <b>5+</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electrical Engineer</b>			16b. Kind of Business/Industry <b>US Government</b>	
17. Father's Name (First, Middle, Last) <b>Grover Cleveland Kirby</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary E. Thompson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Jeanette L. Kirby- wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John Vianey Cemetery</b>		Date <b>Sept 1 2000</b>		20c. Location - City or Town, State <b>Prince Frederick MD</b>	
21. Signature of Funeral Service Licensee <b>B. Rausch</b>		22. Name and Address of Facility <b>Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republic MD 20676</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
Immediate Cause (Final disease or condition resulting in death)		a. <b>Gastrointestinal bleeding</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>days</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):					
		c. Due to (or as a consequence of):					
		d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's</b> <b>Pernicious anemia</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and Title of certifier <b>Robert Schlager</b>				29c. License number <b>D16823</b>		29d. Date signed (Month, Day, Year) <b>8/30/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert Schlager Prince Frederick MD 20678</b>							
31. Date filed (Month, Day, Year) <b>SEP 01 2000</b>		32. Registrar's Signature <b>Shirley S. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30175

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD LORD, JR.

2. Date of Death

Month Day Year  
September 6, 2000

3. Time of Death

6:25 PM

4a. Facility Name (If not institution, give street and number)

E. W. McCready Memorial Hospital

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

219-46-3892

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 18, 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13 Columbia Ave.

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married 2 ☐ Married  
 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

 Armed Forces?  
 1 ☐ Yes 2 ☒ No  
 If Yes, Give  
 Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Paving Contractor

17. Father's Name (First, Middle, Last)

Harold Lord

18. Mother's Name (First, Middle, Maiden Surname)

Barbara Sneade

19a. Informant's Name/Relationship (Type, Print)

Barbara S. Pruitt (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Columbia Ave. - Crisfield, MD 21817

20a. Method of Disposition

 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Salisbury Crematory


Date

9/8/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

  
 Robert H. Bradshaw

22. Name and Address of Facility

 Bradshaw & Sons Funeral Home  
 306 W. Main St. - Crisfield, MD 21817

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)
 a. RESPIRATORY ARREST  
 Due to (or as a consequence of):

 b. RESPIRATORY FAILURE  
 Due to (or as a consequence of):

 c. SLEEP APNEA  
 Due to (or as a consequence of):

 d. \_\_\_\_\_  
 Due to (or as a consequence of):
Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

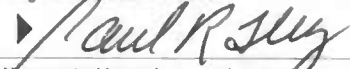
27. Manner of Death

 1 ☒ Natural 5 ☐ Pending  
 2 ☐ Accident investigation  
 3 ☐ Suicide 6 ☐ Could not be  
 4 ☐ Homicide determined
28e. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

024872

29d. Date signed (Month, Day, Year)

9/7/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul R. Fleury, M.D. - Cedar &amp; Tenth Streets - Pocomoke City, MD 21851

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1942-1943, 1944-1945

1946-1947, 1948-1949

1950-1951, 1952-1953

1954-1955, 1956-1957

1958-1959, 1960-1961

1962-1963, 1964-1965

1966-1967, 1968-1969

1970-1971, 1972-1973

1974-1975, 1976-1977

1978-1979, 1980-1981

1982

1983

1984

1985

1986-1987

1988-1989

1990

1991-1992

1993-1994

1995-1996, 1997-1998

1999-2000, 2001-2002

2003-2004, 2005-2006

2007

2008-2009, 2010-2011

2012-2013, 2014-2015

2016-2017

2018-2019

2020-2021, 2022-2023

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30176

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Estelle Layman				2. Date of Death Month Day Year September 8, 2000		3. Time of Death 11:21 A.M.	
	4a. Facility Name (If not institution, give street and number) Northampton Manor Nursing Home				4b. City, Town, or Location of Death Frederick		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 214-18-8814		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) July 31, 1916	
	9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Frederick	
To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State Maryland 10b. County Frederick 10c. City, Town or Location Frederick				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 200 East 16th Street	
	10f. Zip Code 21701		10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Seamstress				16b. Kind of Business/Industry Tailoring company			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Henry Claggett				18. Mother's Name (First, Middle, Maiden Surname) Minnie Herrell			
	19a. Informant's Name/Relationship (Type, Print) Patricia L. Brown/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 North Market Street, Frederick, Md. 21701			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State Sept. 11, 2000 Frederick, Md.	
	21. Signature of Funeral Service Licensee Richard C. C. Bayne M00021				22. Name and Address of Facility Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia</u> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 1 week							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Severe arthritis, recurrent urinary tract infections, multiple strokes</u>							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier Dr. J. J. [Signature]				29c. License number D35183		29d. Date signed (Month, Day, Year) 9/10/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ali J. [Signature] 300 W 9th St Frederick MD							
State Registrar	31. Date filed (Month, Day, Year) SEP 11 2000				32. Registrar's Signature [Signature]			



Amended #2, nls,  
9/12/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 30177

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Edward McKenzie</b>				2. Date of Death Month Day Year <b>09/10/00 2000</b>				3. Time of Death <b>12:52 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>215-42-4286</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 25, 1943</b>		9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent				10a. State <b>MD</b>		10b. County <b>Allegany</b>		10c. City, Town or Location <b>Cresaptown</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>14032 Cedarwood Drive</b>				10f. Zip Code <b>21502</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>tire builder</b>				16b. Kind of Business/Industry <b>tire company</b>		
17. Father's Name (First, Middle, Last) <b>Clarence A. McKenzie</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ora F (Lease)</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Julie M Christopher</b> daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>317 McKenzie Lane; Cumberland, MD21502</b>						
20a. Place of Disposition (Name of cemetery, crematory or other place) <b>Lease Cemetery</b>		20b. Date <b>9/13/</b>		20c. Location - City or Town, State <b>Cresaptown, MD</b>						
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Scarpelli Funeral Home P.A. Cumberland, Maryland 21502</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Arteriosclerotic Heart Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Unknown yrs.</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 				29c. License number <b>D09157</b>		
29d. Date signed (Month, Day, Year) <b>SEPT 10, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Snow M.D. 124 W. 3rd Street Cumberland MD 21502</b>						
31. Date filed (Month, Day, Year) <b>SEP 12 2000</b>				32. Registrar's Signature 						

Aug 8 1912



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State of Maryland / Department of Health and Mental Hygiene

00 30178

Amended item #1 per doctor FCHD, KS Certificate of Death 09/05/2000 Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

James Robert Mason

2. Date of Death

September 2, 2000

3. Time of Death

0255

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

232-50-8644

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 20, 1933

9. Birthplace (State or Foreign Country)

W. Va.

Usual Residence of Decedent

10e. State

MD.

10b. County

Washington

10c. City, Town or Location

Keedysville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5 Millrace Lane

10f. Zip Code

21756

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1953-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

teacher

16b. Kind of Business/Industry

public school

17. Father's Name (First, Middle, Last)

Raymond Elias Mason

18. Mother's Name (First, Middle, Maiden Summa)

Edith Wadsworth

19a. Informant's Name/Relationship (Type, Print)

Judy G. Mason (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Millrace Lane, Keedysville, MD. 21756

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

9/3

20c. Location - City or Town, State

Smithsburg, MD.

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home  
31 E. Main St., Middletown, MD. 21769

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multisystem organ failure

Approximate Interval Between Onset and Death

8 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peritoneal Sepsis

5 days

c. Ischemic Colon

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

September 2, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK GONZALEZ The Johns Hopkins Hospital, Baltimore, MD

31. Date filed (Month, Day, Year)

SEP 05 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30179

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT CURTIS MICHAEL</b>				2. Date of Death Month Day Year <b>SEPTEMBER 9, 2000</b>		3. Time of Death <b>11:35 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>220-18-0823</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 6, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>750 Carroll Parkway</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Test Unit Operator/Machinist</b>		16b. Kind of Business/Industry <b>Fort Detrick</b>				
17. Father's Name (First, Middle, Last) <b>Mantz I. Michael</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>M. Elizabeth Titlow</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Janet L. Michael (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>750 Carroll Parkway, Frederick, Maryland 21701</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resthaven Mem. Gardens</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>		20d. Date <b>9/12/00</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>Bilateral pneumonia</b>					Approximate Interval Between Onset and Death <b>2 days</b>	
		Due to (or as a consequence of):						
		b. <b>Renal insufficiency</b>					<b>2 days</b>	
		Due to (or as a consequence of):						
		c. <b>Cutaneous lymphoma</b>					<b>6 years</b>	
		Due to (or as a consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		d.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D 48184</b>		29d. Date signed (Month, Day, Year) <b>Sept 10/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Elhamy Eskander MD 501 W 7th Street Frederick MD 21701</b>								
31. Date filed (Month, Day, Year) <b>SEP 12 2000</b>		32. Registrar's Signature 						



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30180

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VALERIE JUNE MIGUELE</b>		2. Date of Death Month Day Year <b>SEPTEMBER 9, 2000</b>		3. Time of Death <b>8:00 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>
Funeral Director	5. Social Security Number <b>212-68-4102</b>	8. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>45</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	6. Date of Birth (Month, Day, Year) <b>March 22, 1955</b>		9. Birthplace (State or Foreign Country) <b>Texas</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Frederick</b>	10c. City, Town or Location <b>Frederick</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1327 Hillcrest Drive</b>		10f. Zip Code <b>21703</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Technical Information Assistant</b>		16b. Kind of Business/Industry <b>Government</b>		
	17. Father's Name (First, Middle, Last) <b>Montague I. Young</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Christine L. Brown</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Ricardo A. Miguele, Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1327 Hillcrest Dr., Frederick, Md. 21703</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory, Sept. 10, 2000</b>		20c. Location - City or Town, State <b>Smithsburg, Md.</b>
	21. Signature of Funeral Service Licensed <b>Richard E. [Signature]</b> MO0255		22. Name and Address of Facility <b>Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. ARDS</b> Due to (or as a consequence of):					<b>weeks</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Sepsis</b> Due to (or as a consequence of):					<b>weeks</b>
c. Due to (or as a consequence of):					
d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumothorax</b> <b>Acute Renal Failure</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>MToliva MD</b>		29c. License number <b>MD51610</b>	29d. Date signed (Month, Day, Year) <b>9-9-00</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mike Toliva MD 1475 Tadey Ave Suite 204 Frederick MD 21702</b>					
31. Date filed (Month, Day, Year) <b>SEP 11 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30181

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH MIDDLETON

2. Date of Death

September 4, 2000 1530

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

213-44-4002

6. Sex

10 M 20 F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 15, 1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

240 Shore Acres Way #336

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

William Albert

Middleton

18. Mother's Name (First, Middle, Maiden Surname)

Flora

Reeder

19a. Informant's Name/Relationship (Type, Print)

Victoria Middleton/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 4 Prince Frederick, MD 20678

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greater Bible Way Chr.Cem. 9/11/00 Prince Frederick, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Blayne A. Sewell

22. Name and Address of Facility

Sewell Funeral Home

1451 Dares Beach Rd. Prince Frederick, MD 20678

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA LEFT LUNG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural

20 Accident

30 Suicide

40 Homicide

50 Pending investigation

60 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mukesh Mathur

29c. License number

D-25435

29d. Date signed (Month, Day, Year)

9/4/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mukesh Mathur, M.D.

Prince Frederick, MD 20678

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 05 2000

32. Registrar's Signature

Mukesh Mathur

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

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$\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

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422 20 932



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30182

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |   |                                      |  |  |
|---|---|--|---|---|--|--|---|--------------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Modesto Marusic</b>  |  |   |   | 2. Date of Death<br>Month <b>August</b> Day <b>29</b> Year <b>2000</b>   |  |   |                                      | 3. Time of Death<br><b>8:57PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>45039 Scotch Neck Road</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Hollywood</b>   |  |   |                                      | 4c. County of Death<br><b>St. Mary's</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>061-32-9030</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>August 29, 1919</b>     |                                      | 9. Birthplace (State or Foreign Country)<br><b>Croatia</b>   |  |
|   | Usual Residence of Decedent   |  |   |   | 10a. State<br><b>Maryland</b>  |  |   |                                      | 10b. County<br><b>St. Mary's</b>   |  |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br><b>Hollywood</b>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                      |  |  |
|   | 10e. Street and Number<br><b>45039 Scotch Neck Road</b>   |  |   |   | 10f. Zip Code<br><b>20636</b>  |  |   |                                      | 10g. Citizen of What Country?<br><b>U. S. A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>                          |   |  |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>               |                                      |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Matteo Marusic</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maria Pavincic</b>   |  |   |                                      |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Walter Marusic, son</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>44890 Clarks Mill Road, Hollywood, Maryland 20636</b>                                    |  |   |                                      |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. John's Church Cemetery</b>                                       |   | Date<br><b>9/1/00</b>  |  | 20c. Location - City or Town, State<br><b>Hollywood, Maryland</b> |                                      |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Reginald J. [Signature]</i>   |  |   |   | 22. Name and Address of Facility<br><b>Sterling Funeral Service</b><br><b>1601 Kenilworth Avenue, Washington, DC 20019</b>   |  |   |                                      |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Multiple myeloma</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   |  |  |   |                                      | Approximate Interval Between Onset and Death<br><b>~5 yrs</b>  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiomyopathy</b>   |  |   |   |  |  |   |                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |                                      |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |                                      |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how Injury occurred    |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |                                      |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   | 29b. Signature and title of certifier<br><b>Dr. Kiran D. Mehta</b>  |  |  |   | 29c. License number<br><b>D36206</b> |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>08/31/00</b>  |   |  |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Kiran D. Mehta 24035 Three Notch Road, Hollywood, Maryland</b>   |  |  |   |                                      |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 31 2000</b>   |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |   |                                      |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30183

amend item 23a,ptII, 27 per me G788 10/25/00 yf

|   |   |  |   |  |                                       |
|---|---|--|---|--|---------------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thomas (nmn) Nowakowski</b>                |  | 2. Date of Death<br>Month <b>September</b> Day <b>20</b> Year <b>2000</b> |  | 3. Time of Death<br><b>06:05 A.M.</b> |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>580 Trimble Road</b> |  | 4b. City, Town, or Location of Death<br><b>Joppa</b>                      |  | 4c. County of Death<br><b>Harford</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-50-9327</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.                          | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.        |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 7, 1949</b>                                |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>               |  |                                       |
| Usual Residence of Decedent   |   |  |   |  |                                       |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Harford</b>  |   | 10c. City, Town or Location<br><b>Joppa</b>  |                                       |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |                                       |
| 10e. Street and Number<br><b>580 Trimble Road</b>   |   | 10f. Zip Code<br><b>21085</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |                                       |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                       |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |   |  |                                       |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Singer</b>   |   | 16b. Kind of Business/Industry<br><b>Entertainer</b>   |                                       |
| 17. Father's Name (First, Middle, Last)<br><b>Wilbert Walenty Nowakowski</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sophie (nmn) Kropkowski</b>  |   |  |                                       |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dawn S. Frederick / Fiancee</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>580 Trimble Rd., Joppa, MD 21085</b>   |   |  |                                       |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>   |   | 20c. Location - City or Town, State<br><b>9-22-00 Towson, Maryland</b>   |                                       |
| 21. Signature of Funeral Service Licensee<br><i>Charles A. Emery</i>  |   | 22. Name and Address of Facility<br><b>McComas Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Maryland 21009</b>  |   |  |                                       |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PANCARDITIS</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |   |  |                                       |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |                                       |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |                                       |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |                                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHILDHOOD RHEUMATIC FEVER</b>  |   |  |   |  |                                       |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b> |   |  |                                       |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |                                       |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |                                       |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |  |                                       |
| 29b. Signature and title of certifier<br><i>Stephen S. Radentz, M.D.</i>  |   | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>September 21, 2000</b>   |                                       |
| 30. Name and address of person who completed cause of death (Item 23d) (Type, Print)<br><b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |   |  |                                       |
| 31. Date filed (Month, Day, Year)<br><b>SEP 25 2000</b>   |   | 32. Registrar's Signature<br><i>Benjamin B. Sparks</i>   |   |  |                                       |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30184

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PERRY NORTH

2. Date of Death  
Month Day Year  
September 12 20003. Time of Death  
3:05 pm

4a. Facility Name (If not institution, give street and number)

Mallard Bay Care Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director5. Social Security Number  
218-34-96166. Sex  
☒ M ☐ F7. Age (in yrs. last birthday)  
96 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
Dec. 03 19039. Birthplace (State or Foreign  
Country)  
Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1340 Hudson Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: white15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

farmer

16b. Kind of Business/Industry

grain

17. Father's Name (First, Middle, Last)

Lake North

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Elizabeth Marshall

19a. Informant's Name/Relationship (Type, Print)

Mrs. Frances N. Collins-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 Nanticoke Rd., Cambridge MD 21613

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Old Trinity Churchyard 9-16-2000 Church Creek, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

L. L. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home PA  
700 Locust St. Cambridge MD 2161323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute myocardial infarction

hrs.

Due to (or as a consequence of):

b. Acute pulmonary edema

hrs.

Due to (or as a consequence of):

c. Coronary artery disease

years.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of injury  
(Month, Day, Year)28b. Time of  
injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Ahmed Nawaz

29c. License number

D0050987

29d. Date signed (Month, Day, Year)

9-13-00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ahmed Nawaz 300 Annon Street Cambridge MD

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

B. Sparks

21613

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30185

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |   |  |
|---|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Gordon Norcross</b>                         |   |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>3</b> Year <b>2000</b> |  | 3. Time of Death<br><b>11:38 PM</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>                 |  | 4c. County of Death<br><b>Frederick</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>087-01-0859</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.                         |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug., 8, 1906</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>  |  | 10c. City, Town or Location<br><b>Adamstown</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>5614 Mountville Road</b>   |  | 10f. Zip Code<br><b>21710</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Editor</b>  |  | 16b. Kind of Business/Industry<br><b>Magazine Publication</b>  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Byron B. Gordon</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angie Ball</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Crutchley, co-executor/friend</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 Boileau Court, Middletown, Maryland 21769</b>   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>   |  | 20c. Date<br><b>9/5/2000</b>   |  | 20d. Location - City or Town, State<br><b>Middletown, Maryland</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Ryan M. Bey</b> MO0999  |  |   |  | 22. Name and Address of Facility<br><b>Keeney and Basford Funeral Home</b><br><b>106 East Church Street, Frederick, MD 21701</b>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial ischemic</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | Approximate Interval Between Onset and Death<br><b>hours</b>  |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>R. HEGAZI</b>   |  | 29c. License number<br><b>D44184</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9-5-00</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A-Z. HEGAZI, MD 801 TOLLHOUSE Bldg, Frederick MD 21701</b>   |  |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 07 2000</b>   |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30186

|  |  |   |  |   |   |   |   |  |  |  |  |
|--|--|---|--|---|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Nancy Carol Orrison  |   |  |   | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 7, 2000 |   |   |  | 3. Time of Death<br>18:10 PM                         |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>1/2 MILE EAST OF POINT OF ROCKS RR STATION |   |  |   | 4b. City, Town, or Location of Death<br>POINT OF ROCKS  |   |   |  | 4c. County of Death<br>FREDERICK                     |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>231-52-2766   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>57 Yrs.               |   | 8. Date of Birth (Month, Day, Year)<br>July 2, 1943 |  | 9. Birthplace (State or Foreign Country)<br>Virginia |  |  |
|  | Usual Residence of Decedent  |   |  |   |   |   |   |  |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Frederick  |  | 10c. City, Town or Location<br>Middletown   |   |   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br>2803 Grandview Drive   |  |   |  | 10f. Zip Code<br>21769  |   |   |   | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>1  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Underwriting Specialist  |   |   |   | 16b. Kind of Business/Industry<br>Insurance Company  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>John Wesley Hillman   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Martha Marshall  |   |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mr. R. Donald Orrison, husband   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2803 Grandview Dr., Middletown, Maryland 21769   |   |   |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Resthaven Memorial Gardens, Sept. 12, 2000                                  |  | Date<br>Frederick, Md.  |   | 20c. Location - City or Town, State   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Richard E. Grop MO0255  |  |   |  | 22. Name and Address of Facility<br>Keeney and Basford P.A. Funeral Home<br>106 East Church St., Frederick, Md. 21701   |   |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Multiple Injuries<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |  |   |   |   |   |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |  |   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE |   |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br>9/7/00   |  | 28b. Time of Injury (Hour, Min)<br>1707 M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred<br>Subject Struck by Train                                       |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Train Tracks   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Point of Rocks, Maryland  |   |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |   |   |   |  |  | 29b. Signature and title of certifier<br>Joseph Pestaner, M.D.   |  |
| 29c. License number<br>O.C.M.E.  |  |   |  | 29d. Date signed (Month, Day, Year)<br>SEPTEMBER 8, 2000  |   |   |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |   |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 11 2000   |  |   |  | 32. Registrar's Signature<br>B. Spaw  |   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30187

Amended item #30, 9/12/2000, E.T. WCHD

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joy Olga Pankoff</b>  |  | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>10</b> Year <b>2000</b>   |  | 3. Time of Death<br><b>10:00 A.M.</b>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>Berlin Nursing &amp; Rehabilitation Center</b>  |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>   |  | 4c. County of Death<br><b>Worcester</b>   |  |
| 5. Social Security Number<br><b>103-24-7690</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>12/04/1930</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Switzerland</b>  |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Bishopville</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>13324 Cove Landing RD</b>  |  | 10f. Zip Code<br><b>21813</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>University</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Gaston Prival</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Martha (unknown)</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>George Pankoff - Husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13324 Cove Landing RD, Bishopville, Md 21813</b>  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cape Henlopen Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Frankford, DE</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>108 William Street<br/>The Burbage Funeral Home Berlin, MD 21811</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>a. Respiratory arrest</b><br><b>b. Respiratory failure</b><br><b>c. Metastatic Lung Ca</b><br><b>d. Lung Ca</b> |  | Approximate Interval Between Onset and Death  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Debilitation</b><br><b>Brain Metastatic Lesions</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. Certifier (check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><b>D-0048221</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>9/11/00</b>  |  | 29e. Date of Death (Month, Day, Year)<br><b>9/12/00</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A.M. Spunk, MD, 18 mason dixon slip over selbyville DE 19975</b>  |  | 31. Data filed (Month, Day, Year)<br><b>SEP 12 2000</b>   |  |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>  |  |   |  |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

PANKOFF, JOY

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30188

|   |   |   |  |  |   |  |  |   |
|---|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Christopher Shinn Pennypacker</b>                            |   |  |  | 2. Date of Death<br>Month Day Year<br><b>September 04, 2000</b> |  | 3. Time of Death<br><b>8:20 P.M.</b>     |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Cedar Street and Dorchester Avenue</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cambridge</b>        |  | 4c. County of Death<br><b>Dorchester</b> |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-19-3502</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>16</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 3, 1984</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Dorchester</b>  |  | 10c. City, Town or Location<br><b>Cambridge</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |
| 10e. Street and Number<br><b>115 High Street</b>  |   |   |  | 10f. Zip Code<br><b>21613</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>  |   | 16b. Kind of Business/Industry   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Norman H. Pennypacker, Jr.</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Madeleine Ann Shinn</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Madeleine Shinn/Mother</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>115 High St., Cambridge, MD 21613</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenlawn Cemetery</b>   |  | Data<br><b>9-8</b>   |   | 20c. Location - City or Town, State<br><b>Cambridge, MD</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Curran-Bromwell</i>   |   |   |  | 22. Name and Address of Facility<br><b>Curran-Bromwell Funeral Home, P.A.<br/>308 High St., Cambridge, MD 21613</b>  |   |  |  |   |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.   |   |   |  |  |   |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)   |   | a. <b>Multiple injuries</b><br>Due to (or as a consequence of):   |  |  |   |  |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |   | b. Due to (or as a consequence of):   |  |  |   |  |  |   |
|   |   | c. Due to (or as a consequence of):   |  |  |   |  |  |   |
|   |   | d. Due to (or as a consequence of):   |  |  |   |  |  |   |
|   |   |   |  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |   |  |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
|   |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b> |  |  |   |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)<br><b>9-4-2000</b>  |  | 28b. Time of Injury<br><b>1930</b> M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>DP+L Building Tower -</b>  |  | 28d. Describe how injury occurred <b>Subject precipitated from a height</b>  |   |  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Stephen A. Radentz, M.D.</i>  |  | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>September 05, 2000</b>   |  |   |
| 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>Stephen Radentz, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 07 2000</b>   |   | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |   |  |  |   |

ORIGINAL

Handwritten signature and date: 10/10/36



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State of Maryland / Department of Health and Mental Hygiene

00 30189

## Certificate of Death

Reg. No.

|   |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
|---|--|------------------------------------|---|---|--|--|--|---|---|----|------------------|----------------------------------|--------------|----|---------------------------------|----------------------------------|--------------|----|--------------------------|----------------------------------|--------------|----|------------------|----------------------------------|--------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SARAH ALMA PIPPIN</b>   |                                    |   |   | 2. Date of Death<br>Month Day Year<br><b>Aug. 26, 2000</b>   |  | 3. Time of Death<br><b>9:40PM</b>  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Meredian-Corsica Hills Nursing Center</b> |                                    |   |   | 4b. City, Town, or Location of Death<br><b>Centreville</b>   |  | 4c. County of Death<br><b>Queen Anne's</b>   |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-76-4181</b>  |                                    | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 24, 1905</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                 |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
|   | Usual Residence of Decedent  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Queen Anne's</b> |   | 10c. City, Town or Location<br><b>Centreville</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 10e. Street and Number<br><b>2501 Centreville Road</b>  |  |                                    |   | 10f. Zip Code<br><b>21617</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)   |  |                                    |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Self</b>  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 17. Father's Name (First, Middle, Last)<br><b>James L. Coursey</b>  |  |                                    |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Sara A. Sheubrooks</b>  |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan F. Pippin Grand-Daughter</b>   |  |                                    |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 Maryland Ave., Annapolis, Md. 21401</b>  |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                    |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Aug. 31, 2000</b><br><b>Chesterfield Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Centreville, Md.</b>                         |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 21. Signature of Funeral Service Licensee<br><b>Thomas K. Helfenbein</b>  |  |                                    |   | 22. Name and Address of Facility<br><b>Fellows, Helfenbein &amp; Newnam Funeral Home</b><br><b>408 S. Liberty Street, Centreville, Md.</b>  |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>pneumonia</b></td> <td>Due to (or as a consequence of):</td> <td><b>weeks</b></td> </tr> <tr> <td>b.</td> <td><b>congestive heart failure</b></td> <td>Due to (or as a consequence of):</td> <td><b>month</b></td> </tr> <tr> <td>c.</td> <td><b>failure to thrive</b></td> <td>Due to (or as a consequence of):</td> <td><b>weeks</b></td> </tr> <tr> <td>d.</td> <td><b>hypoxemia</b></td> <td>Due to (or as a consequence of):</td> <td><b>weeks</b></td> </tr> </table> |  |                                    |   |   |  |  |  |   | Immediate Cause (Final disease or condition resulting in death) | a. | <b>pneumonia</b> | Due to (or as a consequence of): | <b>weeks</b> | b. | <b>congestive heart failure</b> | Due to (or as a consequence of): | <b>month</b> | c. | <b>failure to thrive</b> | Due to (or as a consequence of): | <b>weeks</b> | d. | <b>hypoxemia</b> | Due to (or as a consequence of): | <b>weeks</b> |
| Immediate Cause (Final disease or condition resulting in death)   | a.   | <b>pneumonia</b>                   | Due to (or as a consequence of):  | <b>weeks</b>  |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
|   | b.   | <b>congestive heart failure</b>    | Due to (or as a consequence of):  | <b>month</b>  |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
|   | c.   | <b>failure to thrive</b>           | Due to (or as a consequence of):  | <b>weeks</b>  |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
|   | d.   | <b>hypoxemia</b>                   | Due to (or as a consequence of):  | <b>weeks</b>  |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                    |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |                                    |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
|   |  |                                    |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
|   |  |                                    |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 29b. Signature and title of certifier<br><b>Kathleen Hoey</b>   |  |                                    |   | 29c. License number<br><b>D47627</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>8/28/00</b>                                  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Kathleen Hoey, M.D. 2540 Centreville Rd., Centreville, Md. 21617</b>   |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 31. Date filed (Month, Day, Year)<br><b>AUG 30 2000</b>   |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |
| 32. Registrar's Signature<br><b>B. Sparks</b>   |  |                                    |   |   |  |  |  |   |   |    |                  |                                  |              |    |                                 |                                  |              |    |                          |                                  |              |    |                  |                                  |              |



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State of Maryland / Department of Health and Mental Hygiene

00 30190

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Edward S. Paylor, Jr.</b>                     |   | 2. Date of Death<br>Month <b>Sept. 4,</b> Day <b>2000</b> Year     |  | 3. Time of Death<br><b>3:55 PM</b>       |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>       |  | 4c. County of Death<br><b>Montgomery</b> |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-54-5215</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.                   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.           |
|  | 8. Date of Birth (Month, Day, Year)<br><b>July 20, 1943</b>                                  |   | 9. Birthplace (State or Foreign Country)<br><b>Washington D.C.</b> |  |  |
| Usual Residence of Decedent  |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>2445 Lyttonsville Road - Apt. 211</b>  |  | 10f. Zip Code<br><b>20910</b>  |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega</b>            |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Director of Operations</b>   |  | 16b. Kind of Business/Industry<br><b>Property Management Company</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Edward S. Paylor, Sr.</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elaine Zepp</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kimberly Lynn Hiban - Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6440 Mellow Wine Way, Columbia, Maryland 21044</b> |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematorium</b>   |  | 20c. Location - City or Town, State<br><b>9/8/2000 Alexandria, Virginia</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Olin L. Molesworth</b>   |  | 22. Name and Address of Facility<br><b>Olin L. Molesworth P.A., Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872-0117</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>b. Acute Respiratory Failure</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Gastric Carcinoma with wide spread metastases</b>   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Suresh C. Gupta</b>  |  | 29c. License number<br><b>D14876</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9.7.2000</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Suresh C. Gupta, M.D. 4701 Randolph Road, Rockville, Maryland 20852</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 08 2000</b>  |  | 32. Registrar's Signature<br><b>B. Spaw</b>   |  |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30191

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Herbert Quade, Sr.

2. Date of Death

Month Day Year  
Sept. 5, 2000

3. Time of Death

2:25 pm.

4a. Facility Name (If not institution, give street and number)

1695 Lottie Fowler Road

4b. City, Town, or Location of Death

Pr. Frederick

4c. County of Death

Calvert

Funeral  
Director

5. Social Security Number

212-30-0343

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr. 13, 1931

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1695 Lottie Fowler Road

10f. Zip Code

20678

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

State Government

17. Father's Name (First, Middle, Last)

Richard Henry Quade

18. Mother's Name (First, Middle, Maiden Surname)

Julia Burch

19a. Informant's Name/Relationship (Type, Print)

Margaret N. Quade/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1695 Lottie Fowler Rd, Prince Frederick, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Central Cemetery

Date

9/8/00 Barstow, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Raymond-Wood F.H., P.A.  
P.O. Box 430, Dunkirk, MD 2075423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Small Cell Lung Cancer

Approximate  
Interval Between  
Onset and Death

17 months

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Bruce A. Silver, MD

29c. License number

D21463

29d. Date signed (Month, Day, Year)

7-6-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bruce A. Silver, MD 110 Hospital Rd, Prince Frederick, MD

31. Date filed (Month, Day, Year)

SEP 06 2000

32. Registrar's Signature

B. Sparks

20678

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Amended #26, nhl,  
9/19/00, Allegany Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30192

|  |  |                                |  |  |   |   |  |  |   |   |  |
|--|--|--------------------------------|--|--|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Walter William Ruthenberg</b>                 |                                |  |  | 2. Date of Death<br>Month <b>Sept.</b> Day <b>08</b> Year <b>2000</b>   |   |  |  | 3. Time of Death<br><b>7:34am</b>                     |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>74 Chesapeake Drive</b> |                                |  |  | 4b. City, Town, or Location of Death<br><b>Havre de Grace</b>   |   |  |  | 4c. County of Death<br><b>Harford</b>                 |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>399-05-6334</b>  |                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Sep 26, 1920</b> |  | 9. Birthplace (State or Foreign Country)<br><b>WI</b> |   |  |
|  | Usual Residence of Decedent  |                                |  |  |   |   |  |  |   |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Allegany</b> |  | 10c. City, Town or Location<br><b>Frostburg</b>  |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |  |
| 10e. Street and Number<br><b>17009 Old National Pike SW</b>  |  |                                |  | 10f. Zip Code<br><b>21532</b>  |   | 10g. Citizen of What Country?<br><b>USA</b> |  |  |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Date <b>1945-46</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |                                |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Police Officer</b>   |   |   | 16b. Kind of Business/Industry<br><b>Milwaukee Police</b>  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Richard Ruthenberg</b>   |  |                                |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen (nmn)</b>   |   |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorothy Ruthenberg</b><br><b>Wife</b>   |  |                                |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17009 Old National Pike; Frostburg MD 21532</b>   |   |  |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Scarpelli Funeral Home</b>  |   | Date<br><b>9/12/</b>                        |  | 20c. Location - City or Town, State<br><b>Cresaptown, MD</b>                                   |   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                                |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home, P.A.</b><br><b>Cumberland, MD 21502</b>   |   |   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Metastatic Rectal Cancer</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                |  |  |   |   |  |  |   | Approximate Interval Between Onset and Death<br><b>6 months</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CORONARY ARTERY DISEASE</b>   |  |                                |  |  |   |   |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |                                |  |  |   |   |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                |  |  |   |   |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                |  |  |   |   |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Son's Home</b> |   |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |                                |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred                               |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |                                |  | 29b. Signature and title of certifier<br><br><b>MD</b>  |   |   |  | 29c. License number<br><b>038409</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>9/8/00</b>            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William Sigmund, 10753 Faus Rd, Baltimore, Md, 21093</b>  |  |                                |  |  |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |  |                                |  | 32. Registrar's Signature<br>   |   |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

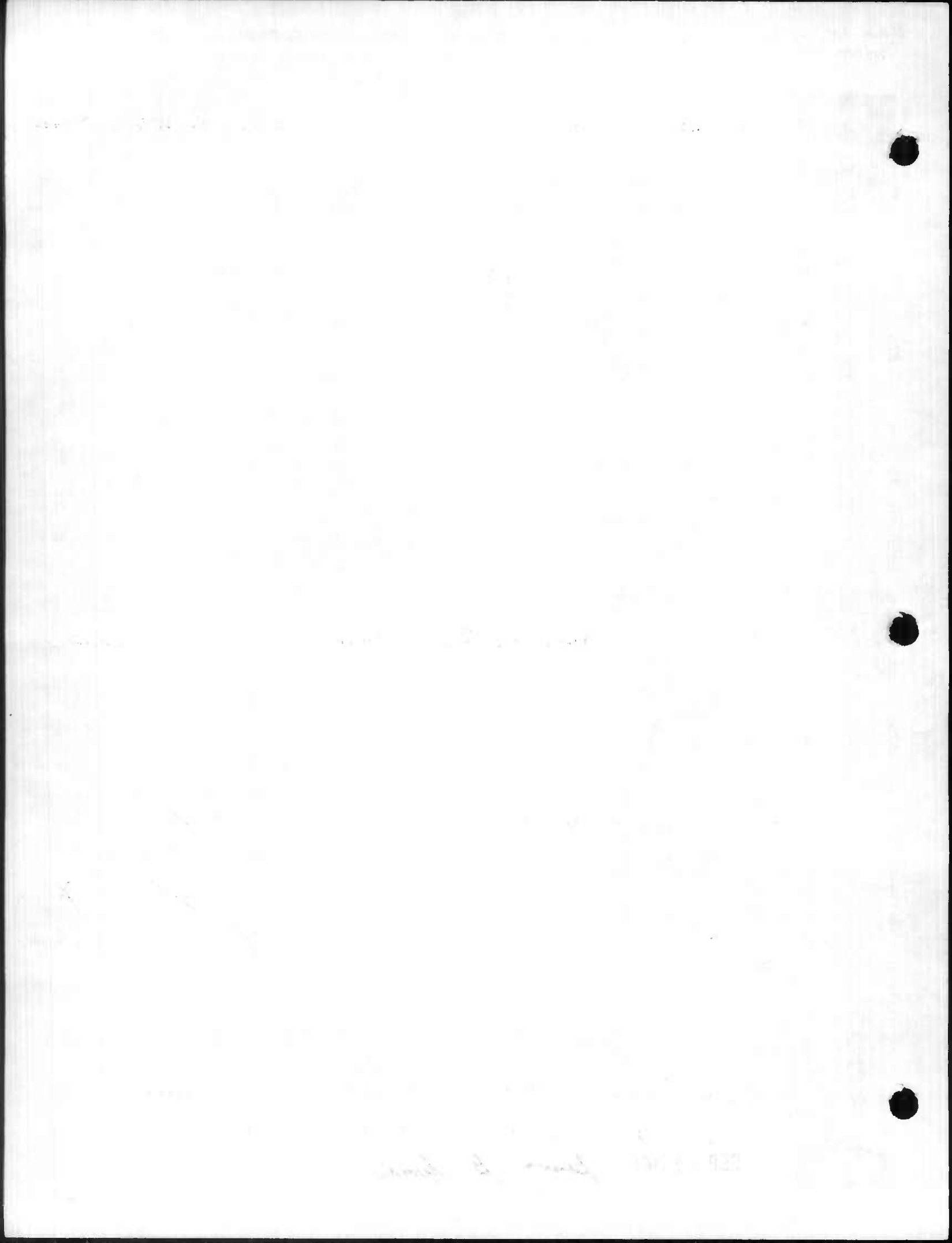
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30193

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bonnie Marie

RICHARDS

2. Date of Death

August 31, 2000

3. Time of Death

10:51am

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

577-12-0828

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

OCT 24 1917

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

POOLESVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17000 HUGHES RD.

10f. Zip Code

20837

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER/HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

CHADSIE EARL ROBINETTE

18. Mother's Name (First, Middle, Maiden Surname)

OLLIE KERLEY

19a. Informant's Name/Relationship (Type, Print)

MARY ZAJDEL/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17000 HUGHES RD., POOLESVILLE, MD 20837

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GATE OF HEAVEN CEMETERY

Data

9/2

20c. Location - City or Town, State

SILVER SPRING, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HILTON FUNERAL HOME

P.O. BOX 86, BARNESVILLE, MD 20838

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

HYPOXIC ENCEPHALOPATHY

Approximate Interval Between Onset and Death

3 days

Due to (or as a consequence of):

CARDIAC ARREST

3 days

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26540

29d. Date signed (Month, Day, Year)

AUGUST 31, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL I. SCHOENBERGER, MD 16220 FREDERICK RD., GAITHERSBURG, MD 20877

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 05 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30194

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA STEVENS</b>  |   | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>8</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>15:48</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |   | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>   |  | 4c. County of Death<br><b>Calvert</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>226 42 7528</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 25, 1918</b>                  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Calvert</b>   | 10c. City, Town or Location<br><b>Solomons</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>11601 Asbury Circle Box 547</b>   |   | 10f. Zip Code<br><b>20688</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>teacher</b>                       |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |   | 16b. Kind of Business/Industry<br><b>public school</b>  |  |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>James Thomas Bowling</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Viola Lyon</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley S. Menefee- daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 481 St. Leonard, Maryland 20685</b>  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>IaPlata UM Dentsville Cemetery</b>                                   |  | 20c. Location - City or Town, State<br><b>Dentsville Maryland</b>  |
|  | 21. Signature of Funeral Service Licensee<br><b>B. Rausch</b>  |   | 22. Name and Address of Facility<br><b>Rausch Funeral Home, PA<br/>4405 Brookes Is. Rd. Port Republic MD 20676</b>                                |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Brain Tumor</b><br>Due to (or as a consequence of):<br><br><b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b><br><b>Parkinson's disease</b><br><b>Diabetes</b><br><b>Hypertension</b> |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Dr. Joseph Barth MD</b>  |  | 29c. License number<br><b>D0052242</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>September 9, 2000</b>              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. JOSEPH BARTH, MD., PRINCE FREDERICK, MD 20678</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |   |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30195

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |                                 |   |  |  |   |  |   |  |   |  |
|---|--|--|---|---|--|---------------------------------|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DOROTHY VIRGINIA SHEELEY</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 6, 2000</b>   |                                 |   |  | 3. Time of Death<br><b>3:15 A.M.</b>   |   |  |   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>COLLEGE VIEW CENTER</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>FREDERICK</b>   |                                 |   |  | 4c. County of Death<br><b>FREDERICK</b>  |   |  |   |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-24-1779</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 11, 1925</b>         |  | 9. Birthplace (State or Foreign Country)<br><b>WOODSBORO, MD.</b>  |   |  |   |  |   |  |
|   | Usual Residence of Decedent  |  |   |   |  |                                 |   |  |  |   |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>FREDERICK</b>   |   | 10c. City, Town or Location<br><b>EMMITSBURG</b>   |                                 |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |   |  |
|   | 10e. Street and Number<br><b>10318 HARNEY ROAD</b>   |  |   |   | 10f. Zip Code<br><b>21727</b>  |                                 | 10g. Citizen of What Country?<br><b>U. S. A.</b>                    |  |  |   |  |   |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                 |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |   |  |   |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>  |                                 |   | 16b. Kind of Business/Industry<br><b>CAMBRIDGE RUBBER COMPANY</b>                    |  |   |  |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>GLENN WILLIAM BEARD</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARIE SPRAGUE</b>  |                                 |   |  |  |   |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>NORMAN LEROY SHEELEY/SON</b>  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>230 COMPANY FARM RD., YORK SPRINGS, PA. 17372</b>  |                                 |   |  |  |   |  |   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>EMMITSBURG MEMORIAL CEMETERY 9/9</b>                                     |   |  |                                 | 20c. Location - City or Town, State<br><b>EMMITSBURG, MD. 21727</b> |  |  |   |  |   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>John M. Stiles</i>   |  |   |   | 22. Name and Address of Facility<br><b>SKILES FUNERAL HOME<br/>210 W. MAIN ST., EMMITSBURG, MD. 21727</b>  |                                 |   |  |  |   |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Severe Anemia</b><br>Due to (or as a consequence of):<br>b. <b>Rectal Cancer</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |                                 |   |  |  |   | Approximate Interval Between Onset and Death<br><b>9 months<br/>1 1/2 year</b> |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                 |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                 |   |  |  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                 |   |  |  |   |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |   |  |   |  |
|   |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |                                 |   |  |  | 29b. Signature and title of certifier<br><i>[Signature]</i> |  | 29c. License number<br><b>D51643</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 6, 2000</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Shah Hiren, MD 170 Thomas Johnson Dr # 100 Frederick MD 21702</b>  |  |  |   |   |  |                                 |   |  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 07 2000</b>     |  | 32. Registrar's Signature<br><i>[Signature]</i> |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene 00 30196

## Certificate of Death

Reg. No.

|   |   |   |  |                                |  |  |   |  |
|---|---|---|--|--------------------------------|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>EDWIN FELTON SHAVER   |   |  |                                | 2. Date of Death<br>Month Day Year<br>SEPT. 6 2000   |  | 3. Time of Death<br>1418  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER   |   |  |                                | 4b. City, Town, or Location of Death<br>SALISBURY  |  | 4c. County of Death<br>WICOMICO   |  |
| Funeral<br>Director   | 5. Social Security Number<br>236-48-9500  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>May 29, 1933   | 9. Birthplace (State or Foreign Country)<br>West Virginia   |  |
|   | Usual Residence of Decedent   |   |  |                                |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>Wicomico   | 10c. City, Town or Location<br>Sharptown   |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br>506 Corporation Road  |   |  | 10f. Zip Code<br>21861         |  | 10g. Citizen of What Country?<br>USA   |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korea |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Grocery Store Owner              |                                | 16b. Kind of Business/Industry<br>Food   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Walter B. Shaver   |   |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lottie M. Felton  |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Alice M. Shaver/Wife  |   |  |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>506 Corporation Rd., Sharptown, MD 21861  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Springhill Memory Gardens  |                                | Date<br>9/9/00   | 20c. Location - City or Town, State<br>Hebron, MD  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>Keith R. Kearney   |   |  |                                | 22. Name and Address of Facility<br>Holloway Funeral Home Professional Association<br>501 Snow Hill Rd., Salisbury, MD 21804   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cardiopulmonary Failure</i><br>Due to (or as a consequence of):<br>b. <i>Multiorgan Organ Failure</i><br>Due to (or as a consequence of):<br>c. <i>Death</i><br>Due to (or as a consequence of):<br>d. <i>Pneumonia AAA</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |  |                                |  |  |   | Approximate Interval Between Onset and Death   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |                                |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |                                |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |                                |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M       | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>Michael S. Sparks  |  | 29c. License number<br>D 52198 |  | 29d. Date signed (Month, Day, Year)<br>9/7/00  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael S. Sparks, M.D. PRMC 100 E. Carroll St. Salisbury, MD 21801   |   |   |  |                                |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>SEP 08 2000  |   | 32. Registrar's Signature<br>B. Sparks  |  |                                |  |  |   |  |

Received of Mr. J. H. [illegible]  
the sum of \$100.00  
for [illegible]  
[illegible]

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State of Maryland / Department of Health and Mental Hygiene 00 30197

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |   |
|---|--|--|--|--|---|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Oliver Glenn Travers Jr.</b>                    |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Sept. 10, 2000</b> |  | 3. Time of Death<br><b>1303</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>The Memorial Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Easton</b>       |  | 4c. County of Death<br><b>Talbot</b>                                    |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-36-2444</b>  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 23, 1940</b> |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |
|   | Usual Residence of Decedent  |  |  |  |   |  |   |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Dorchester</b>   |  | 10c. City, Town or Location<br><b>Cambridge</b>  |   |  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                     |   |
| 10e. Street and Number<br><b>503 Muir Street Apt. 104</b>   |  |  |  | 10f. Zip Code<br><b>21613</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                  |   |   |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:                                |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Crab Picker</b>   |   |  | 16b. Kind of Business/Industry<br><b>Seafood Industry</b>               |   |
| 17. Father's Name (First, Middle, Last)<br><b>Oliver H. Travers SR.</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bernice Ross</b>   |   |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Emma Travers</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>503 Muir Street Apt. 104 Cambridge, MD. 21613</b>                            |   |  |   |   |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cambridge Crematory</b>   |  |  | Date<br><b>9/11/2000</b>                                    |  | 20c. Location - City or Town, State<br><b>Cambridge, Maryland</b>       |   |
| 21. Signature of Funeral Service Licensee<br><b>Janelle C. Henry</b>  |  |  |  | 22. Name and Address of Facility<br><b>HENRY FUNERAL HOME P.A.<br/>510 Washington St. Cambridge, MD. 21613</b>   |   |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br>b. <b>Hypotension</b><br>Due to (or as a consequence of):<br>c. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br>d. <b>End stage renal disease</b> |  |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>12 days</b><br><b>9 days</b><br><b>9 days</b><br><b>6/00</b>       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b><br><b>anemia</b><br><b>Degenerative disease of lumbar spine</b>  |  |  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |   |  |   |   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |  |   |   |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No             |   | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |   |
| 29a. Certifier (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |   |  |   |   |
| 29b. Signature and title of certifier<br><b>Syed I. Ali</b>   |  |  |  | 29c. License number<br><b>D0046020</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>9/10/00</b>        |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Syed I. Ali, M.D., 506 Idlewild Avenue, Easton, MD 21601</b>   |  |  |  |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |  | 32. Registrar's Signature<br><b>Syed I. Ali</b>  |  |  |   |  |   |   |

ORIGINAL

SEP 18 2000

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State of Maryland / Department of Health and Mental Hygiene

00 30198

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |  |  |
|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>DRIS THOMAS</u>   |  |  |  | 2. Date of Death<br>Month <u>9</u> Day <u>2</u> Year <u>2000</u>  |  | 3. Time of Death<br><u>0600</u>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>College View Center</u>   |  |  |  | 4b. City, Town, or Location of Death<br><u>Frederick</u>  |  | 4c. County of Death<br><u>Frederick</u>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>577-38-3574</u>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><u>72</u> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><u>June 1, 1928</u>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><u>D.C.</u>  |  | 10a. State<br><u>Maryland</u>  |  | 10b. County<br><u>Frederick</u>   |  | 10c. City, Town or Location<br><u>Frederick</u>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><u>8328-B Ball Road</u>  |  | 10f. Zip Code<br><u>21704</u>   |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Defense Mapping Agency</u>   |  | 16b. Kind of Business/Industry<br><u>U.S. Government</u>  |  | 17. Father's Name (First, Middle, Last)<br><u>Edwin Messick</u>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Dorothy Radcliffe</u>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Mark S. Thomas, Jr. (Husband)</u>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>8328-B Ball Road, Frederick, Maryland 21704</u>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Springfield Cemetery</u>  |  | 20c. Date<br><u>9/6/00</u>   |  | 20d. Location - City or Town, State<br><u>Sykesville, Maryland</u>  |  | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |  |
|   | 22. Name and Address of Facility<br><u>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.</u><br><u>1201 NORTH MARKET ST., FREDERICK, MD 21701</u>                                 |  | 23a. Per 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><u>ATHEROSCLEROTIC CARDIOVASCULAR DIS</u><br>Due to (or as a consequence of):<br>b. <u>CHRONIC OBSTRUCTIVE LUNG DIS</u><br>Due to (or as a consequence of):<br>c. <u></u><br>Due to (or as a consequence of):<br>d. <u></u> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)<br><u>9/5/00</u>  |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><u>AT HOME</u>  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><u>AT HOME</u>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u>1855 GREEN TREE RD, PIKEVILLE MD</u>  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><u>[Signature]</u>  |  |
|   | 29c. License number<br><u>D20333</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>9/5/00</u>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>K. ZONIER MD 1855 GREEN TREE RD, PIKEVILLE MD</u>  |  | 31. Date filed (Month, Day, Year)<br><u>SEP 06 2000</u>  |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><u>[Signature]</u>  |  | 33. Date of Death<br><u>9/5/00</u>   |  | 34. Time of Death<br><u>0600</u>  |  | 35. Place of Death<br><u>AT HOME</u>   |  |
|   | 36. Signature of Registrar<br><u>[Signature]</u>   |  | 37. Date of Death<br><u>9/5/00</u>   |  | 38. Time of Death<br><u>0600</u>  |  | 39. Place of Death<br><u>AT HOME</u>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





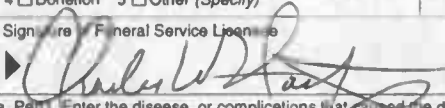
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State of Maryland / Department of Health and Mental Hygiene

00 30199

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EMMA LOUISE TUBBS</b>                                       |   |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>8</b> Year <b>2000</b> |   | 3. Time of Death<br><b>2329</b>                             |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>                 |   | 4c. County of Death<br><b>WICOMICO</b>                      |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-32-4032</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 25, 1921</b>   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|  | Usual Residence of Decedent  |   |  |  |  |   |   |
| 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>WORCESTER</b>   |  | 10c. City, Town or Location<br><b>BISHOPVILLE</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| 10e. Street and Number<br><b>11239 ST. MARTIN'S NECK ROAD</b>  |  |   |  | 10f. Zip Code<br><b>21813</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>LARRY PATEY</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BLANCHE WILKINS</b>  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PRESTON L. TUBBS/HUSBAND</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11239 ST. MARTIN'S NECK RD, BISHOPVILLE, MD 21813</b>                                    |  |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BISHOPVILLE CEMETERY</b>   |  | Date<br><b>9/12/00</b>   |  | 20c. Location - City or Town, State<br><b>BISHOPVILLE, MARYLAND</b>   |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CONGESTIVE HEART FAILURE (DAX)</b><br>Due to (or as a consequence of):<br>b. <b>&amp; PNEUMONIA (DAX)</b><br>Due to (or as a consequence of):<br>c. <b>ISCHEMIC CARDIOMYOPATHY YRS</b><br>Due to (or as a consequence of):<br>d. <b>AS VLP YRS</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
|  |  | 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |   |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |   |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>020912</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9/9/00</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DENNIS J. CHODNICKI MD 400 EASTERN SHORE DR. SALISBURY, MD.</b>   |  |   |  |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |   |

ORIGINAL





00 30200

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 30201

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |   |   |  |
|---|--|---|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LENORA JANE WYATT</b>                       |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Sept. 10, 2000</b> |   | 3. Time of Death<br><b>7:00 PM</b>                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>10117 Orchard Rd.</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>       |   | 4c. County of Death<br><b>Worcester</b>               |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-28-8791</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth<br>(Month, Day, Year)<br><b>June 30, 1931</b>  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |  |
|   | Usual Residence of Decedent  |   |  |  |   |   |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Berlin</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |
| 10e. Street and Number<br><b>10117 Orchard Rd.</b>  |  |   |  | 10f. Zip Code<br><b>21811</b>  |   | 10g. Citizen of What Country?<br><b>US</b>  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Clerk</b>  |   | 16b. Kind of Business/Industry<br><b>Retail</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles H. Burbage</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Della Timmons</b>   |   |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John Thomas Wyatt</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10117 Orchard Rd., Berlin, Md. 21811</b>   |   |   |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Buckingham Presbyterian 9-13-00 Berlin, Md.</b>  |  | 20c. Location - City or Town, State<br><b>Berlin, Md.</b>  |   | 20d. Date   |   |  |
| 21. Signature of Funeral Service Representative<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>The Burbage Funeral Home<br/>108 William St., Berlin, Md. 21811</b>  |  |  |   |   |   |  |
| 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Breast Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>7 years</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
|   |  |   |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |
|   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |
|   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |   |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.  |  |   |  | 29c. License number<br><b>030690</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>Sept. 12, 2000</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jane E. Martin, M.D., 145 E. Carroll St., Salisbury MD.</b>  |  |   |  |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i> B. Sparks   |  |  |   |   |   |  |



Baby Girl Burgess  
amend item 23a, 27per me G788 10/25/00 yf  
AMEND/8 PER A.B. G787 9-26-2000 JAB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30202

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BABY GIRL BURGESS

2. Date of Death

Month Day Year  
September 08, 2000 6:31 A.M.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

5. Social Security Number

N/A

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

1 06

8. Date of Birth

(Month, Day, Year)  
SEPT. 8, 2000

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

NC

10b. County

Forsyth

10c. City, Town or Location

Winston Salem

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

835 Willow Street

10f. Zip Code

27127

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Keicha E. Burgess

19a. Informant's Name/Relationship (Type, Print)

O.C.M.E.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 Penn Street Baltimore, MD 21201

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph B. Van Sant

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. COMPLICATIONS OF PREMATURITY

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 09, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Benita G Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
00202.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30203

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter

Bentley

2. Date of Death

Month

Day

Year

September 21, 2000

3. Time of Death

12:38 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

NA

5. Social Security Number

217-34-9458

6. Sex

XXM 20 F

7. Age (in yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08-30-37

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

XX Yes 20 No

10e. Street and Number

1509 E. Preston Street

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

Disabled

17. Father's Name (First, Middle, Last)

Elliott Bentley, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Annie Parker

19a. Informant's Name/Relationship (Type, Print)

Stephanie Nathan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1509 E. Preston Street Baltimore, Maryland 21213

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem. 09-28-2000 Owings Mill

Date

20c. Location - City or Town, State

MD

21. Signature of Funeral Service Licensee

Bernard D Johnson

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Sepsis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Brain Tumor, History of Pulmonary Embolism, Deep Venous Thrombosis, Status Post Greenfield Filter.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John Adams, M.D.

29c. License number

89344

29d. Date signed (Month, Day, Year)

9/21/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Adams, M.D. 40 Maryland General Hospital

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Benjamin Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30204

|  |  |                               |   |  |  |  |  |   |
|--|--|-------------------------------|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Henry Brown</i>                                       |                               |   |  | 2. Date of Death<br>Month <i>Sept.</i> Day <i>22</i> Year <i>2000</i>  |  | 3. Time of Death<br><i>7:50 am</i>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Baltimore VA Medical Center</i> |                               |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>   |  | 4c. County of Death  |   |
| Funeral<br>Director  | 5. Social Security Number<br><i>213-64-8730</i>  |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>48</i> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>08/02/1952</i>                                       |   |
|  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>  |                               |   |  |  |  |  |   |
| Usual Residence of Decedent  |  |                               |   |  |  |  |  |   |
| 10a. State<br><i>Maryland</i>  |  | 10b. County<br><i>Harford</i> |   | 10c. City, Town or Location<br><i>Joppa</i>      |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><i>4 Court Drive</i>   |  |                               |   | 10f. Zip Code<br><i>21085</i>                    |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>70-72</i>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+)   |  |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Laborer</i>   |  |  | 16b. Kind of Business/Industry<br><i>Construction</i>                                  |  |   |
| 17. Father's Name (First, Middle, Last)<br><i>Henry R. Brown, Sr.</i>  |  |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Dolores Podles</i>   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Dolores Lowe / Mother</i>   |  |                               |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4 Court Drive Joppa, Maryland 21085</i>  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Sacred Heart of Jesus</i>  |  | Date<br><i>9/26/00</i>   | 20c. Location - City or Town, State<br><i>Baltimore, Maryland</i>                      |  |   |
| 21. Signature of Funeral Service Licensee<br><i>David J. Weber</i>   |  |                               |   |  | 22. Name and Address of Facility<br><i>David J. Weber Funeral Homes, P.A.<br/>401 S. Chester Street Baltimore, Maryland 21231</i>  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |                               |   |  |  |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)  |  |                               |   |  |  |  |  |   |
| a. <i>Multi System Organ Failure</i>   |  |                               |   |  |  |  |  |   |
| Due to (or as a consequence of):   |  |                               |   |  |  |  |  |   |
| b. <i>Adult Respiratory Distress Syndrome</i>  |  |                               |   |  |  |  |  |   |
| Due to (or as a consequence of):   |  |                               |   |  |  |  |  |   |
| c. <i>Renal Failure</i>  |  |                               |   |  |  |  |  |   |
| Due to (or as a consequence of):   |  |                               |   |  |  |  |  |   |
| d. <i>Liver Failure</i>  |  |                               |   |  |  |  |  |   |
| Approximate Interval Between Onset and Death<br><i>48 hours</i>  |  |                               |   |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                               |   |  |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |                               |   |  |  |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                               |   |  |  |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |                               |   |  |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                               | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |                               | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|  |  |                               | 28d. Describe how Injury occurred   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |   |
|  |  |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  |                               | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |  |  |   |
|  |  |                               | 29c. License number<br><i>P14011</i>  |  |  | 29d. Date signed (Month, Day, Year)<br><i>Sept. 25, 2000</i>                           |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Don Yamaguchi 22 S. Greene St. Baltimore MD 21201</i>   |  |                               |   |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><i>SEP 26 2000</i>  |  |                               | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



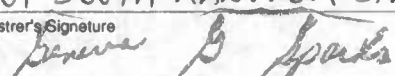
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State of Maryland / Department of Health and Mental Hygiene

00 30205

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LEONARD WILLIAM BOOKER, SR.</b>                  |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 20 2000</b> |  |  | 3. Time of Death<br><b>6:04 PM</b>                         |  |  |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b> |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>       |  |  | 4c. County of Death<br><b>N/A</b>                          |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-10-8262</b>   |  | 6. Sex<br><b>10 M 20 F</b>   |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 5, 1911</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |  |
|  | 10a. State<br><b>Md.</b>  |  |  | 10b. County<br><b>N/A</b>                                      |  |  | 10c. City, Town or Location<br><b>Baltimore</b>            |  |  | 10d. Inside City Limits<br><b>10 Yes 20 No</b> |  |
| 10e. Street and Number<br><b>3726 Tenth Street</b>   |   |  | 10f. Zip Code<br><b>21225</b>  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |  |  |
| 11. Marital Status<br><b>10 Never Married 20 Married 30 Widowed 40 Divorced</b>  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>10 Yes 20 No</b>   |  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>10 Yes 20 No Specify:</b> |  |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>                            |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 9th College (1-4or 5+) 0</b>   |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Glass Cutter</b>                           |  |  | 16b. Kind of Business/Industry<br><b>Glass Company</b>   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Booker</b>   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marie Parks</b>  |  |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mildred N. Booker (Wife)</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3726 Tenth Street Baltimore, Maryland 21225</b>        |  |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><b>10 Burial 20 Cremation 30 Removal from State 40 Donation 50 Other (Specify)</b>   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>  |  |  | 20c. Location - City or Town, State<br><b>9/23/00 Glen Burnie, Maryland</b>  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  | 22. Name and Address of Facility<br><b>Kevin E. Ecker McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore, Maryland 21225</b>             |  |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. SEPSIS</b><br>Dua to (or as a consequence of):<br><b>b. ESOPHAGEAL RUPTURE</b><br>Dua to (or as a consequence of):<br><b>c. MEDIASTINITIS</b><br>Dua to (or as a consequence of):<br><b>d.</b> |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>4 DAYS</b><br><b>4 DAYS</b><br><b>4 DAYS</b>  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>MULTIFOCAL ATRIAL TACHYCARDIA</b>   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>10 Yes 20 No 30 Probably 40 Unknown</b>   |  |  | 24a. Was an autopsy performed?<br><b>10 Yes 20 No</b>  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>10 Yes 20 No</b> |  |  |
| 25. Was case referred to medical examiner?<br><b>10 Yes 20 No</b>  |   |  | 26. Place of Death (Check only one)<br>Hospital: <b>10 Inpatient 20 ER/Outpatient 30 DOA</b> Other: <b>40 Nursing Home 50 Residence 60 Other (Specify)</b> |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><b>10 Natural 20 Accident 30 Suicide 40 Homicide 50 Pending Investigation 60 Could not be determined</b>  |   |  | 28a. Date of Injury (Month, Day, Year)   |  |  | 28b. Time of Injury<br><b>M</b>  |  |  | 28c. Injury at Work?<br><b>10 Yes 20 No</b>  |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  | 28d. Describe how injury occurred  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><b>10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>   |   |  | 29b. Signature and title of certifier<br><b>Amit Kestogi MD</b>  |  |  | 29c. License number<br><b>812805</b>   |  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER, 20, 2000</b>                                  |  |  |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>AMIT KESTOGI, 3001 SOUTH HANOVER STREET, BALTIMORE, MD-21225</b>  |   |  |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





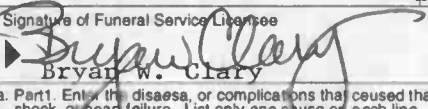
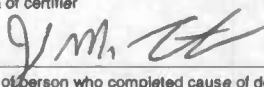
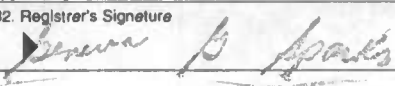
CLIFTON EUGENE BOSLEY  
ASP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30206

amend item 23a,27,28a,b,c,d,e,fper me G788 10/4/00 yf Certificate of Death

Reg. No.

|  |   |  |  |   |  |  |  |  |
|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Clifton Eugene Bosley</b>                |  |  | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>23</b> Year <b>2000</b> |  |  | 3. Time of Death<br><b>0527</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>325 WARREN RD,</b> |  |  | 4b. City, Town, or Location of Death<br><b>COCKEYSVILLE</b>               |  |  | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>159-56-1339</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 20, 1962</b>                                   |  |
|  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Cockeysville</b> |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>n/a</b>   |   |  |  |   |  |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fork Lift Operator</b>  |   |  | 16b. Kind of Business/Industry<br><b>Corrugated Box Factory</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Clifton Bosley</b>  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Doris Mildred Neeley</b>   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Doris M. Bosley/Mother</b>  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>325 Warren Road, Cockeysville, MD 21030</b>  |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore-Washington Crematory</b>  |   |  | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>Bryan W. Clary</b>   |   |  | 22. Name and Address of Facility<br><b>Lemmon Funeral Home</b><br><b>10 W. Padonia Road, Timonium, MD 21093</b>  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. NARCOTIC AND COCAINE INTOXICATION</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b> |   |  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |  |  |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  |   |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |   |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day, Year)<br><b>found 9/23/00</b>   |   | 28b. Time of Injury<br><b>found 5:20 A M</b>       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>residence</b>   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>325 Warren Road, Cockeysville, Md.</b>   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br><br><b>J.M. Titus</b>  |   |  | 29c. License number<br><b>O.C.M.E</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 23, 2000</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACK M. TITUS, M.D.</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   |  | 32. Registrar's Signature<br>  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30207

|   |  |   |  |   |  |   |  |  |
|---|--|---|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary A. Button</b>  |   |  |   | 2. Date of Death<br>Month <b>Sept</b> Day <b>24</b> Year <b>2000</b>   |   | 3. Time of Death<br><b>7:35pm</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>COPPER RIDGE</b>  |   |  |   | 4b. City, Town, or Location of Death<br><b>SYKESVILLE</b>  |   | 4c. County of Death<br><b>CARROLL</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-01-2770</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (in yrs. last birthday)<br><b>92</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>2/28/1908</b>  |  |
|   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Upperco</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>manager</b>  |   | 16b. Kind of Business/Industry<br><b>clothing</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Abraham N. Leister</b>   |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna B. Sprinkle</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard F. Geoghegan cousin</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>727 Blue Heron Reach Lane Chesapeake City MD 21915</b>                                       |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>9/27/00 Elkridge, MD</b>                             |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |  |   | 22. Name and Address of Facility<br><b>11824 Reisterstown Road<br/>Eline Funeral Home Reisterstown, MD 21136</b>   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Bilateral Pneumonia</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                      |   |  |   | Approximate Interval Between Onset and Death<br><b>Weeks</b>   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Disease</b>   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|   |  |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|   |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
|   | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                            |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Ernestine Wright</b>  |  | 29c. License number<br><b>D52740</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Sept 25th 2000</b>                                |  |  |
| State Registrar   | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Ernestine Wright, Copper Ridge, Sykesville, Carroll County, MD 21784</b>  |   |  |   |  |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   |  |   | 32. Registrar's Signature<br><i>[Signature]</i>  |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #20B PER F.H. G788 10-20-00 WR  
AMEND ITEM: #19B PER F.H. G787 9-26-00 WR

Certificate of Death

Reg. No. 00 30208

|   |   |   |   |  |  |   |   |  |
|---|---|---|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Calvin F. Banks Sr.</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 19, 2000</b>  |   | 3. Time of Death<br><b>2100 PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |   | 4c. County of Death<br><b>n/a</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-40-6385</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.                                       | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>9-11-1944</b>                 |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>md.</b>  |   |   |  |  |   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |  |  |   |   |  |
|   | 10a. State<br><b>md</b>   |   | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 10e. Street and Number<br><b>1715 E. Oliver St.</b>   |   |   |  | 10f. Zip Code<br><b>21213</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A</b>                           |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>n/a</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Labor</b>  |   | 16b. Kind of Business/Industry<br><b>Beth Steel</b>                     |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>LEROY Banks</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anne He. Pate</b>  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Calvin F. Banks Jr. (son)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5609 LEIDEN RD. Balto. Md. 21206</b>   |   |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST CEM.</b>   |  | Date<br><b>9/19/00</b>   |   | 20c. Location - City or Town, State<br><b>Owings Mills, Md.</b>         |  |
|   | 21. Signature of Funeral Service Licensee<br><b>George Comer</b>  |   |   |  | 22. Name and Address of Facility<br><b>Beths Funeral Home 21213<br/>1129 N. CAROLINE STREET Balto. Md</b>  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
|   |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) |  |   |   |  |
|   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |   |  |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Dennis J. Chuteau</b>   |   |   |   | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 20, 2000</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chuteau 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 25 2000</b>   |   | 32. Registrar's Signature<br><b>Dennis J. Chuteau</b>   |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 30209

Amend Item #1, G787, 9/29/00, per Dr., Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Elwood O. Bass</u>   |  |  |  | 2. Date of Death<br>Month <u>September</u> Day <u>21</u> Year <u>2000</u>  |  |  |  | 3. Time of Death<br><u>3:30 pm</u>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>509 K Cider Press Court</u>  |  |  |  | 4b. City, Town, or Location of Death<br><u>Joppa</u>   |  |  |  | 4c. County of Death<br><u>Harford</u>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>240-01-9099</u>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><u>81</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>November 25, 1918</u>                                |  | 9. Birthplace (State or Foreign Country)<br><u>Durham, N. C.</u>   |  |
|   | 10a. State<br><u>MD</u>   |  | 10b. County<br><u>Harford</u>  |  | 10c. City, Town or Location<br><u>Joppa</u>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><u>509 K Cider Press Court</u>  |  |  |  | 10f. Zip Code<br><u>21085</u>  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>   |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>WW II</u>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                        |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u> <u>12</u>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Electrician</u>  |  | 16b. Kind of Business/Industry<br><u>Steel Company</u>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>Nick B. Bass</u>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Lula Rollins</u>   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><u>Ruthie H. Bass-wife</u>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>509 K Cider Press Ct., Joppa, MD 21085</u>   |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>MD Veterans Cent., Garrison Forest 9/26/00</u>  |  |  |  | 20c. Location - City or Town, State<br><u>Owings Mills, MD</u>                                 |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensed <u>William G. Dau</u>   |  |  |  | 22. Name and Address of Facility<br><u>Leonard J. Ruck Funeral Home, Inc.</u><br><u>5305 Harford Rd. Baltimore, MD 21214</u>   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. Congestive Heart Failure</u><br>Due to (or as a consequence of):<br><u>b. Coronary Artery Disease</u><br>Due to (or as a consequence of):<br><u>c.</u><br>Due to (or as a consequence of):<br><u>d.</u><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  | Approximate Interval Between Onset and Death<br><u>1 year</u><br><u>2 years</u>  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |  |  |
|   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br><u>Reed D. Riley MD</u>   |  |  |  | 29c. License number<br><u>D47560</u>   |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><u>Reed D. Riley MD</u>  |  |  |  | 29c. License number<br><u>D47560</u>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><u>September 22, 2000</u>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Reed D. Riley MD</u> <u>4924 Campbell Blvd. Baltimore MD 21236</u>   |  |  |  |  |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><u>SEP 25 2000</u>   |  |  |  | 32. Registrar's Signature<br><u>[Signature]</u>  |  |  |  |  |  |
|   |   |  |  |  |  |  |  |  |  |  |

ORIGINAL





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AMEND ITEM: #1 PER PHY G789 11-18-00 WR State of Maryland / Department of Health and Mental Hygiene  
Amend Item 1 per phy, 788,10/13/00dhhb

## Certificate of Death

Reg. No. 00 30210

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>HARRY LOTT BROCK JR.</b>                         |   | 2. Date of Death<br>Month <b>September</b> Day <b>18</b> Year <b>2000</b>  |   | 3. Time of Death<br><b>10:12 p.m.</b>       |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |   | 4c. County of Death                         |
| Funeral<br>Director   | 5. Social Security Number<br><b>546-46-6614</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.              |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Apr 21 1935</b>                                       |   | 9. Birthplace (State or Foreign Country)<br><b>California</b>  |   |   |
| Usual Residence of Decedent   |   |   |  |   |   |
| 10a. State<br><b>VA</b>   |   | 10b. County   |  | 10c. City, Town or Location<br><b>Alexandria</b>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |   |   |
| 10e. Street and Number<br><b>314 S St Asaph Street</b>  |   |   | 10f. Zip Code<br><b>22314</b>  |   | 10g. Citizen of What Country?<br><b>USA</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   |   |  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>  |  | 16b. Kind of Business/Industry<br><b>Telecommunications</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Harry L Brock</b>   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Editha Barthel</b>   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Suzanne Brock/Wife</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>314 S St Asaph Street Alex. VA 22314</b> |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Everly Cremaotry</b>   |  | 20c. Location - City or Town, State<br><b>9/21/00 Alexandria, VA</b>  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   | 22. Name and Address of Facility<br><b>Everly-Wheatley Funeral Home</b><br><b>1500 W Braddock Rd. Alex. VA 22302</b>                         |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |   |   |
| Immediate Cause (Final disease or condition resulting in death)   |   | a. <b>sepsis</b>  |  | Approximate Interval Between Onset and Death<br><b>1 week</b>   |   |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   | b. <b>malignant pericardial effusion</b>  |  | <b>1 month</b>  |   |
|   |   | c. <b>renal failure</b>   |  | <b>2 months</b>   |   |
|   |   | d. <b>acute myelogenous leukemia</b>  |  | <b>2 months</b>   |   |
|   |   |   |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |   |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   |
|   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |   |   |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>RES 000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 18, 2000</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kelly Dooley, Johns Hopkins Hospital, Baltimore, Maryland 21287</b>  |   |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br>   |  |   |   |

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State of Maryland / Department of Health and Mental Hygiene

00 30211

AMEND ITEM: #5 PER G787 9-26-00 WR.

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |  |   |
|---|--|--|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JANICE BERNETTA CARTER</b>                              |  |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>18</b> Year <b>2000</b> |  | 3. Time of Death<br><b>1150p</b>   |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Stella Maris At Mercy Hospice</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                  |  | 4c. County of Death<br><b>2/1</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>9219-54-3220</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 19, 1951</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |  |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>7311 PRINCE GEORGE ROAD</b>  |  |  |  | 10f. Zip Code<br><b>21207</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>black</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1 YEAR</b> College (1-4 or 5+)  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurses Assistant</b>   |   | 16b. Kind of Business/Industry<br><b>University of Maryland Medical Systems</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES STANFORD CARTER</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CATHERINE E. RANKINS</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Reiko ALSTON / Daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7311 PRINCE GEORGE ROAD BALTIMORE, MD 21207</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garden of Eternal Hope</b>  |  | Date<br><b>9-23-2000</b>   |   | 20c. Location - City or Town, State<br><b>Hinksbury, NY</b>  |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Gray Harris</b>   |  | 22. Name and Address of Facility<br><b>CHATHAM - HARRIS Funeral Home 5540 REISTERSTOWN ROAD BALTIMORE, MD 21215</b>  |  |  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Colon Cancer</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
|   |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>STELLA MARIS AT MERCY HOSPICE</b> |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                           |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>David Riseberg</b>   |  | 29c. License number<br><b>DH0854</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>9/18/00</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202</b>   |  |  |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  | 32. Registrar's Signature<br><b>James B. Harris</b>  |  |  |   |  |  |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30212

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN COLEMAN

2. Date of Death

Month Day Year  
September 16, 2000

3. Time of Death

06:05 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

214 30 6874

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
4/2/35

9. Birthplace (State or Foreign Country)

N.C.

Usual Residence of Decedent

10a. State

MD.

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2603 CECIL AVE.

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: AFRO AMERICAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DAY CARE PROVIDER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

JAMES HOWARD

18. Mother's Name (First, Middle, Maiden Surname)

HATTIE DAVIS

19a. Informant's Name/Relationship (Type, Print)

PATRICIA THOMPSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2641 W. LAFAYETTE AVE. BALTO. MD. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING, S PARK

Date

9/21/2000

20c. Location - City or Town, State

RANDALLSTOWN MD.

21. Signature of Funeral Service Licensee

Cecil A. Step

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME P.A.  
1300 EUTAW PL. BALTO. MD. 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Deep Venous Thrombosis

Due to (or as a consequence of):

2 weeks

c. Acute Renal Failure

Due to (or as a consequence of):

1 week

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, High Blood Pressure, Arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel Feinstein MD house officer

29c. License number

P12590

29d. Date signed (Month, Day, Year)

September 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Feinstein, MD 900 Laton Ave Baltimore, Maryland 21229

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Benjamin B Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

NAME Helen Coleman

Division of Vital Records, P.O. Box 68760,





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AMEND ITEM#11 PERFH G798 8/08/01 JH

State of Maryland / Department of Health and Mental Hygiene 00 30213

Amended Item#20b perFHG787 9/29/2000 EW

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Bernice B. Carpenter</b>                         |  | 2. Date of Death<br>Month <b>09</b> Day <b>22</b> Year <b>2000</b>   |  | 3. Time of Death<br><b>4:10p.m.</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Nursing Home</b> |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-62-8161</b>   | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|  | 6. Date of Birth (Month, Day, Year)<br><b>12 28 43</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>M.D.</b>  |  |  |
| Usual Residence of Decedent  |   |  |  |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |  |
| 10e. Street and Number<br><b>2505 Whitney Ave</b>  |   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b>   |   | College (1-4 or 5+) <b>na</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Associate</b>  |  |
| 16b. Kind of Business/Industry<br><b>K-Mart</b>  |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James T. Roberts</b>   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Woodland</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lisa Carpenter-Daughter</b>   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5017 Pembridge Ave, Baltimore Md 21215</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>  |  | Date <b>28</b><br>20c. Location - City or Town, State<br><b>9/29/00 Glen Burnie, Md</b>  |  |
| 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore Md 21215</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Breast cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>2 1/2 years</b> |   |  |  |  | Approximate Interval Between Onset and Death<br><b>2 1/2 years</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>025205</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 22, 2000</b>   |  |
| 30. Name and address of person who completed cause of death (23a) (Type, Print)<br><b>W.A. Riley G.B.M.C. 6701 N. Charles St. Balto. md 2120x</b>  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   | 32. Registrar's Signature<br>   |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

00 30214

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HERMA LEE CATTERTON

2. Date of Death

Month Day Year  
SEPTEMBER 22 2000

3. Time of Death

11:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

218-28-6047

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

SEPT. 5, 1933

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10a. State  
MARYLAND10b. County  
ANNE ARUNDEL10c. City, Town or Location  
JESSUP

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7489 MONTEVIDEO COURT

10f. Zip Code

20794

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

MILLARD

YATES

18. Mother's Name (First, Middle, Maiden Surname)

EVA

ARMS

19a. Informant's Name/Relationship (Type, Print)

CHARLENE HARDEE (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1318 CRAGHILL COURT, HANOVER, MARYLAND 21076

20a. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MEADOWRIDGE MEMORIAL PARK

Date

9/26/2000

20c. Location - City or Town, State

ELKRIDGE, MD.

21. Signature of Funeral Service Licensee

Paul A. Hagan

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A.,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ISCHEMIC BOWEL SYNDROME

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 day

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Stage III Non Small cell carcinoma of lung

Severe Cardiomyopathy with heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

K. Atluri, MD (Resident physician)

29c. License number

P14435

29d. Date signed (Month, Day, Year)

09/22/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KALPANA ATLURI, RESIDENT, HARBOR HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30215

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |   |  |
|---|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>James Richard Carter</b>                       |   |  |   | 2. Date of Death<br>Month <b>SEPT</b> Day <b>23</b> Year <b>2000</b> |  | 3. Time of Death<br><b>8:33pm</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>6 Spring Haven Court</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Severna Park</b>          |  | 4c. County of Death<br><b>Anne Arundel</b>                |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>198-20-2585</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 2, 1930</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                   |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Anne Arundel</b>                                   |  | 10c. City, Town or Location<br><b>Severna Park</b>        |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>6 Spring Haven Court</b>   |  | 10f. Zip Code<br><b>21146</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sheet Metal Fabricator/Procurement Manufacturing</b>  |  | 16b. Kind of Business/Industry  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lewis Richard Carter</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elsie Mae Myers</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Carter/wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 Spring Haven Court Severna Park, MD 21146</b>   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>  |  | Date<br><b>9/25/00</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Dawn F. McDonald</b>  |   | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>   |  |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pancreatic cancer</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   |   |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|   |   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|   |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>Dawn F. McDonald</b>  |   |   |  | 29c. License number<br><b>D40854</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9-25-00</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dawn F. McDonald 301 St Paul Pl Baltimore MD 21202</b>   |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br><b>Benjamin Sparks</b>   |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30216

## Certificate of Death

Reg. No.

|  |   |  |   |                                      |  |  |   |  |
|--|---|--|---|--------------------------------------|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>NELLIE JO-ANN CONWAY COLE</b>  |  |   |                                      | 2. Date of Death<br>Month Day Year<br><b>September 23 2000</b>   |  | 3. Time of Death<br><b>255 Am</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b>  |  |   |                                      | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-16-3055</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 24, 1917</b>                                    |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |
|  | Usual Residence of Decedent   |  |   |                                      |  |  |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>   | 10b. County<br><b>NIA</b>  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>  |                                      |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>4554 DERBY MANOR DRIVE</b>   |  |   | 10f. Zip Code<br><b>21215</b>        |  | 10g. Citizen of What Country?<br><b>USA.</b>   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CERTIFIED NURSING ASSISTANT BALTO CITY HEALTH</b>   |                                      | 16b. Kind of Business/Industry   |  |   |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>OSCEOLA CONWAY</b>  |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MISSOURI GRAY</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LISA COLE (DAUGHTER)</b>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4554 DERBY MANOR DR. BALTIMORE, MD. 21215</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS CEMETERY</b>   |                                      | 20c. Location - City or Town, State<br><b>9-29-00 BALTIMORE, MD.</b>   |  | 20d. Date   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME<br/>2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>   |                                      |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CVA</b><br>Due to (or as a consequence of):<br><b>b. Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |                                      |  |  |   | Approximate Interval Between Onset and Death<br><b>3 hours</b><br><b>1 day</b>   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b><br><b>Acute Renal Failure</b>  |  |   |                                      |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                      |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                      |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)                                      |   | 28b. Time of Injury<br>M             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>                                  |   | 29c. License number<br><b>RES000</b> |  | 29d. Date signed (Month, Day, Year)<br><b>9-Sept 23, 2000</b>                                  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John Q.A. Mattern, Jr. 2401 W. Belvedere Baltimore, MD 21215</b>  |   |  |   |                                      |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   | 32. Registrar's Signature<br>  |   |                                      |  |  |   |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 30217

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DORIS E. CRONAN</b>                               |  |  |  | 2. Date of Death<br>Month <b>SEPT</b> Day <b>23</b> Year <b>2000</b> |  | 3. Time of Death<br><b>11:17</b>                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>G.B.M.C. GILCHRIST CTR.</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>                |  | 4c. County of Death<br><b>BALTIMORE</b>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-30-3480</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB 23, 1934</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                      |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>HARFORD</b>  |  | 10c. City, Town or Location<br><b>BEL AIR</b>              |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>315 LINWOOD AVE</b>   |  | 10f. Zip Code<br><b>21014</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DRIVING INSTRUCTOR</b>   |  | 16b. Kind of Business/Industry<br><b>SUMMITT DRIVING</b>   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>NEWTON KELLY</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY G. BLADES</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CHERYL L. MYSZKIEWICZ, DAU</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>315 LINWOOD AVE BEL AIR, MD. 21014</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>PARKVILLE, MD.</b>   |  | 20d. Date<br><b>SEP. 26, 2000</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>EVANS FUNERAL CHAPEL</b><br><b>8800 HARFORD RD. PARKVILLE, MD. 21234</b>  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Lung cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | Approximate Interval Between Onset and Death<br><b>2 years</b>   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other <b>Residence</b> |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D39099</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9/24/00</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rodney Williams G.B.M.C. Baltimore</b>   |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 30218

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Augusta R. Cunningham   |   |   |  | 2. Date of Death<br>Month Day Year<br>September 23, 2000   |  | 3. Time of Death<br>3:20PM                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Charlestown Care Center   |   |   |  | 4b. City, Town, or Location of Death<br>Catonsville  |  | 4c. County of Death<br>Baltimore                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br>212-30-0475  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>93 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 6, 1906              |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |   | 10a. State<br>MD  |  | 10b. County<br>Baltimore   |  | 10c. City, Town or Location<br>Catonsville                       |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br>719 Maiden Choice Lane  |  | 10f. Zip Code<br>21228   |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Operator                                 |  | 16b. Kind of Business/Industry<br>C & P Telephone Comp.  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Christian Woppman  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Molley   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Jane Pahl (Daughter)   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4211 Buckingham Road, Baltimore, Maryland 21207   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |  | Date<br>9/26/00  |  | 20c. Location - City or Town, State<br>Baltimore, Maryland       |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road, Randallstown, MD 21133  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Pneumonia</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |  |
|   | Approximate Interval Between Onset and Death<br>1-2 weeks   |   |   |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>diabetes, vascular disease</u>   |   |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|   |   | 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>MD   |   | 29c. License number<br>D47009   |   | 29d. Date signed (Month, Day, Year)<br>September 24, 2000                              |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Phillip Stone 711 Maiden Choice Lane, Baltimore, MD 21228   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 26 2000  |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

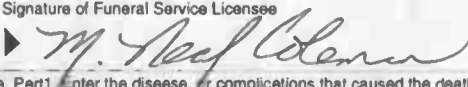
State of Maryland / Department of Health and Mental Hygiene

00 30219

ALBERT RODNEY CARPENTER

Certificate of Death

Reg. No.

|   |  |   |   |                                |  |  |
|---|--|---|---|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT RODNEY CARPENTER</b>   |   | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>20</b> Year <b>2000</b>   |                                | 3. Time of Death<br><b>12:25 A.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>8592 LEONARDTOWN ROAD</b>   |   | 4b. City, Town, or Location of Death<br><b>HUGHESVILLE</b>  |                                | 4c. County of Death<br><b>CHARLES</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>411-86-1074</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>6/29/50</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>TN</b>  |   |   |                                |  |  |
| To Be Completed by Funeral Director                                       | Usual Residence of Decedent  |   |   |                                |  |  |
|   | 10a. State<br><b>NC</b>  | 10b. County<br><b>CUMBERLAND</b>  | 10c. City, Town or Location<br><b>FAYETTEVILLE</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>6704 SANDFIELD COUT</b>   |   | 10f. Zip Code<br><b>28304</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |   |                                |  |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>SFC</b>                        |                                | 16b. Kind of Business/Industry<br><b>U S ARMY</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ROBERT LINCOLN CARPENTER</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIRGINIA HARTMAN</b>  |                                |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>RUCHANEE CARPENTER WIFE</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6704 SANDFIELD CT. FAYETTEVILLE, NC 28304</b> |                                |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ROGERS &amp; BREECE CREMATORY 9/24/00 FAYETTEVILLE, NC</b>           |                                | 20c. Location - City or Town, State  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.<br/>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>                              |                                |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |   |   |                                |  | Approximate Interval Between Onset and Death             |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |                                |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |                                |  |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |                                |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |                                |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |                                |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>   |   |   |                                |  |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |   |                                |  |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 28a. Date of Injury (Month, Day, Year)<br><b>Found 9-20-00</b>   |   | 28b. Time of Injury<br><b>Found 1:30 A M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 28d. Describe how injury occurred<br><b>motor vehicle collision</b>  |   |   |                                |  |  |
|   | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)<br><b>street</b>  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Charles Co., Md</b>  |                                |  |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |                                |  |  |
| State Registrar   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>O.C.M.E.</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 20, 2000</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis Chute 111 Penn Street, Baltimore, Maryland 21201</b>   |   |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>                   |  | 32. Registrar's Signature<br> |   |                                |  |  |





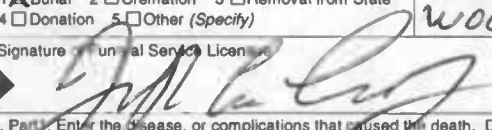

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30220

## Certificate of Death

Reg. No.

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GLADYS CHALLONER</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Sept 23 2000</b>  |  | 3. Time of Death<br><b>7:45p</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOWARD County General Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>HOWARD</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-12-0980</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 18 1910</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>HOWARD</b>   |  | 10c. City, Town or Location<br><b>ELLICOTT CITY</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>3913 JUMPER HILL LANE</b>   |  | 10f. Zip Code<br><b>21042</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BOOKKEEPER</b>   |  | 16b. Kind of Business/Industry<br><b>RESTAURANT</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH WEHNER</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CHARLOTTE VOLPE</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLOTTE BERNHARDT DAUGHTER</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3913 JUMPER HILL LA. ELLICOTT CITY MD 21042</b>  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>9/27/00 WOODLAWN. MD.</b>  |  | 20d. Date  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>JOSEPH L. CANBY FUNERAL DIRECTOR<br/>567 DEER HILL ROAD SYKESVILLE, MD 21784</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>RESPIRATORY FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>c. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>d. <b>PULMONARY Hypertension</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>END STAGE CHRONIC Obstructive Pulmonary Disease</b>  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br><b>Dr. Kalishman, MD</b>  |  | 29c. License number<br><b>D-50184</b>  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>Sept. 23, 2000</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ZHANNA KALICHMAN 4501 Old ANNAPOLIS Rd, Ellicott City, MD 21042</b>   |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  | 32. Registrar's Signature<br> |  |





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State of Maryland / Department of Health and Mental Hygiene 00 30221

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |   |  |
|--|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Noel Lee Case</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>September 21 2000</b>   |  | 3. Time of Death<br><b>2:30 A.M.</b>                                    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Fernbrook Manor</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Odenton</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>208 05 5929</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 25, 1907</b>             |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Mississippi</b>  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Severna Park</b>                      |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
|  | 10e. Street and Number<br><b>111 Evergreen Road</b>   |   |   |  | 10f. Zip Code<br><b>21146</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>                            |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>                      |  | 16b. Kind of Business/Industry<br><b>Marx Toy Company</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Otis William Case</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Georgia Smith</b>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>William Case / Son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>111 Evergreen Road Severna Park, Maryland 21146</b>                                      |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | Date<br><b>9/22/00</b>   |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>          |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |   |   |  | Approximate Interval Between Onset and Death   |  |   |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br><b>Coronary Artery Disease</b>   |   |   |  | <b>10 years</b>  |  |   |  |
| Due to (or as a consequence of):<br><b>Essential Hypertension</b>  |   |   |   | <b>18 years</b>  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   |   |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |   |  |
|  |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |
|  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Assisted</b> |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  |   | 28d. Describe how injury occurred<br><b>Living</b>  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br> M.D.  |   |   |   | 29c. License number<br><b>D0014160</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Sept. 21, 2000</b>                     |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225</b>  |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   | 32. Registrar's Signature<br>   |   |  |  |  |   |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 30222

## Certificate of Death

Reg. No.

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LEONARD STARK COHN</b>                    |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 21, 2000</b> |   | 3. Time of Death<br><b>12:20 PM</b>     |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>2405 HUNT DRIVE</b> |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>        |   | 4c. County of Death<br><b>BALTIMORE</b> |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-28-4510</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.                | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.          |
|  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 27, 1928</b>                              |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>           |   |   |
| Usual Residence of Decedent  |  |  |   |   |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |   |
| 10e. Street and Number<br><b>2405 HUNT DRIVE</b>   |  | 10f. Zip Code<br><b>21209</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII ARMY</b>   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>INSURANCE MANAGER</b>   |   |
| 16b. Kind of Business/Industry<br><b>INSURANCE</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>JOEL COHN</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DORA STARK</b>  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LOIS COHN / WIFE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2405 HUNT DRIVE - BALTIMORE, MD 21209</b>  |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHIZUK AMUNO (ARLINGTON)</b>  |   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>Jay Clayton Lewis</i>  |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>  |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>acute myocardial infarction</b><br>Due to (or as a consequence of):<br><br>b. <b>coronary artery disease</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>wks</b><br><b>yrs</b>   |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>diabetes mellitus</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of injury<br><b>M</b>   |   |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29e. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>Brian Skatoff MD</i>  |   |
| 29c. License number<br><b>D19261</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9/21/2000</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BRIAN KAHNTROFF MD 21 CROSSROADS #400 21117</b>  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  | 32. Registrar's Signature<br><i>B. Sparks</i>  |   |   |   |

ORIGINAL



00-5379-510

CLARENCE

DILL

AMEND#19A PER F.H. G787 9026-2000 JAB

## Certificate of Death

Reg. No.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30223

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| Physician /Medical Examiner  |  | 1. Decedent's Name (First, Middle, Last)<br><b>CLARENCE DILL</b>   |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 22, 2000</b>  |  | 3. Time of Death<br><b>2:58P.M.</b>   |  |
| Funeral Director   |  | 4a. Facility Name (If not institution, give street and number)<br><b>BON SECOURS HOSPITAL</b>  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>NA</b>  |  |
| 5. Social Security Number<br><b>140-36-6049A</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPTEMBER 7, 1917</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Bermuda</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>2019 W. LANVALE STREET</b>  |  | 10f. Zip Code<br><b>21217</b>  |  | 10g. Citizen of What Country?<br><b>BERMUDA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRICAN AMERICAN</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b><br>College (1-4 or 5+) <b>NA</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>  |  | 16b. Kind of Business/Industry<br><b>HOME</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>JOHN DILL</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARIAN DILL</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>EVANGELINE DILL</b><br><b>EVANGELINE GILL - WIFE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2019 W. LANVALE STREET BALTIMORE, MD 21217</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. JOHN'S CEMETERY</b>   |  | 20c. Date<br><b>9/30/00</b>  |  | 20d. Location - City or Town, State<br><b>PEMBROKE, BERMUDA</b>  |  | 21. Signature of Funeral Service Licensee<br>   |  |
| 22. Name and Address of Facility<br><b>WYLIE FUNERAL HOME PA</b><br><b>638 N. GILMOR STREET BALTIMORE, MD 21217</b>  |  | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>Atherosclerotic Cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Insufficiency</b>   |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>  |  | 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 23, 2000</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  | 32. Registrar's Signature<br>  |  | State Registrar  |  |   |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30224

AMEND ITEMS: #31 PER DVR. G787 9-26-00 WR.

|  |  |   |   |  |                                    |
|--|--|---|---|--|------------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>NETTIE V. DUNN</b>                                |   | 2. Date of Death<br>Month <b>September</b> Day <b>23</b> Year <b>2000</b> |  | 3. Time of Death<br><b>6:46 AM</b> |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b> |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                  |  | 4c. County of Death<br><b>—</b>    |
| Funeral<br>Director  | 5. Social Security Number<br><b>225-30-0138</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.                          | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.     |
|  | 8. Date of Birth (Month, Day, Year)<br><b>JULY 3, 1928</b>                                       |   | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>               |  |                                    |
| Usual Residence of Decedent  |  |   |   |  |                                    |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |   | 10c. City, Town or Location<br><b>PARKVILLE</b>  |                                    |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |                                    |
| 10e. Street and Number<br><b>1712 WENTWORTH AVE</b>  |  | 10f. Zip Code<br><b>21234</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |                                    |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                    |
| 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>   |  |   |   |  |                                    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |   | 16b. Kind of Business/Industry<br><b>DOMESTIC</b>  |                                    |
| 17. Father's Name (First, Middle, Last)<br><b>JESSIE DOYLE</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE FLOYD</b>   |   |  |                                    |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MORRIS DUNN, SPOUSE</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1712 WENTWORTH AVE PARKVILLE, MD. 21234</b>   |   |  |                                    |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>PARKWOOD CEMETERY</b>  |   | 20c. Location - City or Town, State<br><b>PARKVILLE, MD</b>  |                                    |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  | 22. Name and Address of Facility<br><b>EVANS FUNERAL CHAPEL</b><br><b>8800 HARFORD RD PARKVILLE, MD 21234</b>   |   |  |                                    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial infarction</b><br>Due to (or as a consequence of):<br><b>b. Atherosclerosis and low blood perfusion</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   | Approximate Interval Between Onset and Death<br><b>48 hours.</b><br><b>30 hours.</b>   |                                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                    |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |   |  |                                    |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |                                    |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |                                    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |                                    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |                                    |
|  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how Injury occurred  |                                    |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                    |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |                                    |
| 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.   |  | 29c. License number<br><b>D2554</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>September 23, 2000</b>   |                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bryan Nolan, M.D. Good Samaritan Hospital</b>   |  |   |   |  |                                    |
| 31. Date filed (Month, Day, Year)<br><b>September 23, 2000</b>   |  | 32. Registrar's Signature<br><i>[Signature]</i> SEP 26 2000   |   |  |                                    |

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State of Maryland / Department of Health and Mental Hygiene 00 30225  
Certificate of Death

Reg. No.

|                                     |  |  |   |   |  |
|-------------------------------------|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Jeanne Engels  |  | 2. Date of Death<br>Month Day Year<br>September 21, 2000  |   | 3. Time of Death<br>7:15PM   |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>Good Samaritan Nursing Center  |  | 4b. City, Town, or Location of Death<br>Baltimore   |   | 4c. County of Death<br>N/A   |
| Funeral<br>Director                 | 5. Social Security Number<br>327-28-4281   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>80 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Oct. 1, 1919 | 9. Birthplace (State or Foreign Country)<br>ILLINOIS   |
|                                     | Usual Residence of Decedent  |  |   |   |  |
| To Be Completed by Funeral Director | 10a. State<br>MD   | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Baltimore  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|                                     | 10e. Street and Number<br>6825 Campfield Road  |  | 10f. Zip Code<br>21207  |   | 10g. Citizen of What Country?<br>U.S.A.  |
|                                     | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3   |   |  |
|                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Nurse   |  | 16b. Kind of Business/Industry<br>Health Care   |   |  |
|                                     | 17. Father's Name (First, Middle, Last)<br>John Matthew Engels   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hazel Kalter   |   |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Lois Crotty - Sister   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8914 Carlisle Avenue Baltimore, Maryland 21236   |   |  |
|                                     | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Baltimore-Washington Crematory  |   | 20c. Location - City or Town, State<br>Laurel, Maryland  |
|                                     | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, Maryland 21133  |   |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>End Stage Dementia</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Peripheral Vascular Disease</u>   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |  |
|                                     | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.  |  |   |   |  |
|                                     | 29b. Signature and title of certifier<br>  |  | 29c. License number<br>D43725   |   | 29d. Date signed (Month, Day, Year)<br>9/22/00   |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>TARIQ MAHMOUD 201-109 Buck River Neck Rd Baltimore MD 21221  |  |   |   |  |
|                                     | 31. Date filed (Month, Day, Year)<br>SEP 26 2000   |  | 32. Registrar's Signature<br>   |   |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30226

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |   |  |
|---|---|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dora L. Fritz</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>September 21 2000</b>   |  | 3. Time of Death<br><b>9:00 A.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Mariner Health of North Arundel</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216 30 7950</b>   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 9, 1919</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Linthicum</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>604 Eagles Wing Court</b>  |  | 10f. Zip Code<br><b>21090</b>  |  | 10g. Citizen of What Country?<br><b>U.S.</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                         |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Smith</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mattie Bowen</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Daisy Garrison / Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>604 Eagles Wing Court Linthicum, Maryland 21090</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | Date<br><b>9/25/00</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>b. URINO SEPSIS</b><br>Due to (or as a consequence of):<br><b>c. A SCVD</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |  |  |  |   |  |
|   | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>  |   |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br><b>D23530</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9-21-00</b>                                |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Ashok Chatterjee 3927 Annapolis Road Baltimore, Maryland 21227</b>   |   |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br>   |   |  |  |  |   |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30227

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SUSAN

FEIT

2. Date of Death

SEPT

22

2000

3. Time of Death

4:45AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

STELLA MARIS

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

BALTIMORE

5. Social Security Number

215-54-3524

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

NOV

13

1948

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9 WOODHOLME VILLAGE COURT

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SALES REPRESENTATIVE

16b. Kind of Business/Industry

COSMETICS

17. Father's Name (First, Middle, Last)

RONALD

ROSEN

18. Mother's Name (First, Middle, Maiden Surname)

SHIRLEY

COHEN

19a. Informant's Name/Relationship (Type, Print)

IRA FEIT/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 WOODHOLME VILLAGE COURT BALTIMORE, MD. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

BETH EL MEMORIAL PARK

Date

9/24/00

20c. Location - City or Town, State

RANDALLSTOWN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. CANCER OF VAGINA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

9/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

S. P. Parks

ORIGINAL

SEPTEMBER 22, 2000 4:45 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

SUSAN FEIT

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30228

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Julia

Graham

2. Date of Death  
Month Day Year

SEPTEMBER 23 2000

3. Time of Death

7:10 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

212-28-8479

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

09-20-31

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1110 N. Patterson Park Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

East Wood Inn

17. Father's Name (First, Middle, Last)

William Isadora Banks, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Smith

19a. Informant's Name/Relationship (Type, Print)

Brady Graham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1110 N. Patterson Park Baltimore, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Nat'l Cem. 09-28-2000 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bernard D. Johnson

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PULMONARY EMBOLISM

Approximate Interval Between Onset and Death

2 hours

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

SEPSIS

2 weeks

Due to (or as a consequence of):

END STAGE RENAL DISEASE

2 YEARS

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Loreen Puthumana, MD

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

SEPTEMBER 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOREEN J PUTHUMANA, UNION MEMORIAL HOSPITAL, BALTIMORE, MD.

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Bernard D. Johnson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30229

|                                     |   |  |  |  |   |  |  |  |   |  |  |  |
|-------------------------------------|---|--|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALICE MAY LEWIS GEYER</b>  |  |  |  | 2. Date of Death<br>Month <b>SEPT.</b> Day <b>21</b> Year <b>2000</b>   |  |  |  | 3. Time of Death<br><b>8:16pm</b>   |  |  |  |
|                                     | 4a. Facility Name (If not Institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  |  |  | 4c. County of Death<br><b>N/A</b>   |  |  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>214-40-5584</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>06/14/1902</b> |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  |
|                                     | Usual Residence of Decedent   |  |  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>                                |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |  |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>215 EAST NORTHERN PARKWAY</b>  |  |  |  | 10f. Zip Code<br><b>21212</b>   |  |  |  |
|                                     | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |  |  |
|                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4YRS.</b>   |  |  |  |
|                                     | 16. Kind of Business/Industry<br><b>EDUCATION</b>   |  |  |  | 17. Father's Name (First, Middle, Last)<br><b>RICHARD G. LEWIS</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EVA EMMA YOUSE</b>  |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>SARA FRANCES FAIDLEY(SIS.)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>215 EAST NORTHERN PARKWAY BALTO., MD. 21212.</b>  |  |  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |  |  |  |
|                                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEM.</b>   |  |  |  | 20c. Location - City or Town, State<br><b>09/25/2000 BALTO., MD.</b>  |  |  |  | 21. Signature of Funeral Service Licensee<br>   |  |  |  |
|                                     | 22. Name and Address of Facility<br><b>HENRY W. JENKINS &amp; SONS CO.<br/>4905 YORK RD. BALTO., MD. 21212.</b>   |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Acute Myocardial Infarction</b>  |  |  |  | Approximate Interval Between Onset and Death<br><b>8 Hrs.</b>   |  |  |  |
|                                     | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|                                     | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |  |  |
|                                     | 28a. Date of injury (Month, Day, Year)  |  |  |  | 28b. Time of injury<br><b>M</b>   |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
| 28d. Describe how injury occurred   |   |  |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>013454</b>  |  |  |  |
|                                     | 29d. Date signed (Month, Day, Year)<br><b>September 21, 2000</b>  |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LINDA LINDSEY M.D. 5601 LOCH RAVEN BLVD. BALTO., MD.</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 20 2000</b>   |  |  |  |
|                                     | 32. Registrar's Signature<br>  |  |  |  | State Registrar   |  |  |  |   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30230

|   |  |  |   |   |  |   |   |  |   |   |   |  |  |  |  |
|---|--|--|---|---|--|---|---|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BETTY J. GARRISON</b>                                   |  |   |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 21 2000</b>   |   |   |  | 3. Time of Death<br><b>8:00 P.M.</b>                        |   |   |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MARINER HEALTH OF FOREST HILL</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>FOREST HILL</b>   |   |   |  | 4c. County of Death<br><b>HARFORD</b>                       |   |   |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-28-5988</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 7, 1928</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |   |  |  |  |  |
|   | Usual Residence of Decedent  |  |   |   |  |   |   |  |   |   |   |  |  |  |  |
| 10a. State<br><b>Md</b>   |  | 10b. County<br><b>N/A</b>                    |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |  |  |  |  |
| 10e. Street and Number<br><b>4105 Buena Vista Ave.</b>  |  |  |   | 10f. Zip Code<br><b>21211</b>   |  |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |   |  |  |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |   |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4th</b> College (1-4 or 5+)   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  |   |   | 16b. Kind of Business/Industry<br><b>at Own Home</b>   |   |   |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Raymond M. Garrison</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lillie M. Axt</b>   |  |   |   |  |   |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gordon Garrison (Brother)</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>606 Linwood Ave, Bel Air, MD 21014</b>  |  |   |   |  |   |   |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>   |  | Date<br><b>9/25</b>   |   | 20c. Location - City or Town, State<br><b>Pikesville, MD</b>   |   |   |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |   | 22. Name and Address of Facility<br><b>Burgee-Henss-Seitz Funeral Home, Inc.<br/>3631 Falls Rd. Balto, MD 21211</b>   |  |   |   |  |   |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |   |   |  |   |   |  |   |   |   |  |  |  |  |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>pneumonia</u><br/>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. <br/>Due to (or as a consequence of):</td> </tr> </table> |  |  |   |   |  |   |   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>pneumonia</u><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death | b.<br>Due to (or as a consequence of): | c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. <u>pneumonia</u><br>Due to (or as a consequence of):  | Approximate Interval Between Onset and Death |   |   |  |   |   |  |   |   |   |  |  |  |  |
|   | b.<br>Due to (or as a consequence of):   |  |   |   |  |   |   |  |   |   |   |  |  |  |  |
|   | c.<br>Due to (or as a consequence of):   |  |   |   |  |   |   |  |   |   |   |  |  |  |  |
|   | d.<br>Due to (or as a consequence of):   |  |   |   |  |   |   |  |   |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>advanced dementia</u>  |  |  |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |   |  |  |  |  |
|   |  |  |   |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  |  |  |
|   |  |  |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |   |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)        |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |   |   |   |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |   |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   |   |  |   |   |  |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>032295</b>  |  |   |   | 29d. Date signed (Month, Day, Year)<br><b>September 25, 2000</b>   |   |   |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID S. DRURY 615 W. MacPherson</b>   |  |  |   |   |  |   |   |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  |  |   | 32. Registrar's Signature<br>   |  |   |   |  |   |   |   |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30231

|   |  |  |  |  |   |  |  |  |
|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ANTONIO GONZALEZ</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPT 23RD 2000</b>   |  | 3. Time of Death<br><b>2:00 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-28-3644</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>07/22/1913</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>PUERTO RICO</b>   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>RIDGELEIGH</b>   |  |
| To Be Completed by Funeral Director           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>PUERTO RICAN</b> |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>HISPANIC</b>   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAMTRESS</b>  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>ENRIQUE GONZALEZ</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CANDIDA GOITIA</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>CARMEN TINKER / DAUGHTER</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1811 REDWOOD AVE.: BALTIMORE, MD 21234</b>  |  |  |  |
| Physician<br>/Medical<br>Examiner             | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MORELAND MEMORIAL PARK</b>   |  | 20c. Location - City or Town, State<br><b>9/25 HILLENDALE, MD</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>THE JOHNSON FUNERAL HOME, P.A.<br/>8521 LOCH RAVEN BLVD.: TOWSON, MD 21286</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><b>b. CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>1 HOURS</b><br><b>75 YEARS</b>   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES, HYPERTENSION</b>  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br>MD   |  |  |  |
|   | 29c. License number<br><b>P12964</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPT 23RD 2000</b>  |  |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ELIZABETH N. NGUYEN GOOD SAMARITAN HOSPITAL MD, 21234</b>   |  |  |  | 31. Data filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  |  |  |
|   | 32. Registrar's Signature<br>  |  |  |  |   |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30232

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carol Ann Graham

2. Date of Death

September 24 2000

3. Time of Death

00:50

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-38-2478

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Aug. 4, 1940

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md.

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

101 Spruce Wood Ct.

10f. Zip Code

21009

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Medical Billing

16b. Kind of Business/Industry

Greater Baltimore

Medical Center

17. Father's Name (First, Middle, Last)

Dewey C. Graham, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ocie Esther Cochran

19a. Informant's Name/Relationship (Type, Print)

Mr. John P. Graham/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Spruce Wood Ct. Abingdon, Ct. 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Andrew's Cemetery

Date

9/29/00

20c. Location - City or Town, State

Roanoke, Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 2120423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. uro sepsis

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

5 Days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Resident

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

September 24 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salomeh Keyhani 301 North Caroline street Baltimore Maryland

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30233

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |   |  |
|--|---|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Joan Marie Graulich</b>                                  |   |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>20</b> Year <b>2000</b> |  | 3. Time of Death<br><b>10:15 A</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris at Mercy Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                  |  | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213 32 3196</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.                          |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 27, 1935</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Glen Burnie</b>           |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>213 Hollywood Court</b>   |   | 10f. Zip Code<br><b>21060</b>  |   |  |
| 10g. Citizen of What Country?<br><b>U.S.</b>   |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales</b>  |   | 16b. Kind of Business/Industry<br><b>Retail</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Oscar L. Moon</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth J. Stockman</b>   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Graulich / Son</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21791</b><br><b>9002 Clemsonville Road Union Bridge, Maryland</b> |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Md. Veteran Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>9/22/00 Crownsville, Maryland</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Jerome Gramuscu</b>  |   |   |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.</b><br><b>4001 Ritchie Highway Baltimore, Md. 21225</b>   |   |  |   |  |
| 23a. Part I. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic lung cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>a. Due to (or as a consequence of):</b><br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
|  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>hospital</b> |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>Dr. [Signature]</b>  |   |   |  | 29c. License number<br><b>D40854</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>9/20/2000</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Doris Roseberg 301 St Paul Pl Baltimore 21202</b>   |   |   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |   |  |   |  |





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State of Maryland / Department of Health and Mental Hygiene

00 30234

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |   |   |  |
|--|--|--|---|--|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>LUCILLE S. GEE</b>  |  |   |  | 2. Date of Death<br>Month <b>09</b> Day <b>22</b> Year <b>00</b>   |  |   |   | 3. Time of Death<br><b>9:45 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>AUGSBURG NURSING HOME</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>N/A</b>   |  |   |   | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-10-7456</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>08-22-26</b>                                      |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |   |   |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|  | 10e. Street and Number<br><b>2212 PRESTMAN STREET</b>  |  |   |  | 10f. Zip Code<br><b>21217</b>  |  |   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 TH GRADE</b>  |  | College (14 or 5+) <b>N/A</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOOD SERVICE</b>   |  |   | 16b. Kind of Business/Industry<br><b>U.S. GOVT.</b>                     |   |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH SMITH</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE ROY</b>  |  |   |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>ARNITA ANTHONY DAUGHTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 LYDIA CT., BALTO. MD. 21208</b>  |  |   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | Date<br><b>9-27-00</b>   |  | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD</b>                              |   |   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>VAUGHN C. GREENE FUNERAL SERVICE</b><br><b>5151 BALTO. NATL PIKE, BALTO. MD. 21229</b>  |  |   |   |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Alzheimer's Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Alzheimer's Disease</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |  |  |   |   | Approximate Interval Between Onset and Death<br><b>years</b>  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |  |   |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |  |   |  |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |  |   |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred   |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |   |   |   |  |
| State Registrar  | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>037573</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 22, 2000</b>                            |   |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jeff Zibell MD 25 Main St Baltimore MD 21136</b>  |  |   |  |  |  |   |   |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  |   |  | 32. Registrar's Signature<br>  |  |   |   |   |  |

ORIGINAL





00 30235

## Reg. No.

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 30236

## Certificate of Death

Reg. No.

|   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
|---|--|------------|---|--|--|--|--|--|--|--|---|--------------------------|-------|--------------------|----------|-----------------|------------|----------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Edith L. Harman  |            |   |  | 2. Date of Death<br>Month Day Year<br>September 24 <sup>th</sup> 2000  |  |  |  | 3. Time of Death<br>0319 A.M.  |  |   |                          |       |                    |          |                 |            |                      |
|   | 4a. Facility Name (If not institution, give street and number)<br>Union Memorial Hospital  |            |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |  |  |  | 4c. County of Death<br>N/A   |  |   |                          |       |                    |          |                 |            |                      |
| Funeral<br>Director   | 5. Social Security Number<br>212-07-4261   |            | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>Yrs. 93  |  | 8. Date of Birth (Month, Day, Year)<br>Sept 8, 1907        |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |                          |       |                    |          |                 |            |                      |
|   | Usual Residence of Decedent  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |            | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>Baltimore   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |                          |       |                    |          |                 |            |                      |
|   | 10e. Street and Number<br>3838 Roland Avenue Apt 105   |            |   |  | 10f. Zip Code<br>21211   |  | 10g. Citizen of What Country?<br>USA                       |  |  |  |   |                          |       |                    |          |                 |            |                      |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |            | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |   |                          |       |                    |          |                 |            |                      |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)<br>Unknown   |            |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cashier   |  |  | 16b. Kind of Business/Industry<br>Parking Garage                 |  |  |   |                          |       |                    |          |                 |            |                      |
|   | 17. Father's Name (First, Middle, Last)<br>George H. Fischer   |            |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth M. Saul   |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br>Elmer Wilt (Nephew)  |            |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9247 Harford View Drive, Baltimore, MD 21234  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |            |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Baltimore National Cem. 9/27/00  |  | 20c. Location - City or Town, State<br>Baltimore, Maryland |  |  |  |   |                          |       |                    |          |                 |            |                      |
|   | 21. Signature of Funeral Service Licensee<br>Lynn B. Henss   |            |   |  | 22. Name and Address of Facility<br>Burgee-Henss-Seitz Funeral Home, Inc. 21211<br>3631 Falls Road, Baltimore, Maryland  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. Myocardial Infarction</td> <td>1 day</td> </tr> <tr> <td>b. Aortic Stenosis</td> <td>7 months</td> </tr> <tr> <td>c. Hypertension</td> <td>&gt; 10 years</td> </tr> <tr> <td>d. Diabetes mellitus</td> <td>&gt; 10 years</td> </tr> </table> |            |   |  |  |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. Myocardial Infarction | 1 day | b. Aortic Stenosis | 7 months | c. Hypertension | > 10 years | d. Diabetes mellitus |
| Immediate Cause (Final disease or condition resulting in death)   | a. Myocardial Infarction   | 1 day      |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
|   | b. Aortic Stenosis   | 7 months   |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
|   | c. Hypertension  | > 10 years |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
|   | d. Diabetes mellitus   | > 10 years |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 28a. Date of Injury (Month, Day, Year)  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 28b. Time of Injury<br>M  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 28d. Describe how injury occurred   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 29b. Signature and title of certifier<br>Michelle M. Collins MD   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 29c. License number<br>AT2438P46  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 29d. Date signed (Month, Day, Year)<br>September 24 <sup>th</sup> 2000  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Union Memorial Hospital 201 East University Parkway Baltimore, Maryland 21218   |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 31. Date filed (Month, Day, Year)<br>SEP 26 2000  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |
| 32. Registrar's Signature<br>B. Sparks  |  |            |   |  |  |  |  |  |  |  |   |                          |       |                    |          |                 |            |                      |



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State of Maryland / Department of Health and Mental Hygiene

00 30237

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |   |   |   |
|---|--|---|--|--|---|---|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GILBERT HYNES</b>                                   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 22, 00</b> |   | 3. Time of Death<br><b>4:10 PM</b>      |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>   |   | 4c. County of Death<br><b>BALTIMORE</b> |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-88-6533</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>36</b> Yrs. | 8. Under 1 Year<br>Months Days   | 8. Under 24 Hrs.<br>Hours Min.                                | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 5, 1964</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |   |  |  |   |   |   |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Rockdale</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
| 10e. Street and Number<br><b>7922 Dunhill Village Circle; #301</b>  |  |   |  | 10f. Zip Code<br><b>21244</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |   |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>-0-</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Hair Stylist</b>   |   | 16b. Kind of Business/Industry<br><b>Hair Salon</b>   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Gilbert Edward Hynes, Sr.</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara J. Phillips</b>  |   |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Gilbert E. Hynes, Sr. - Father</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7922 Dunhill Village Circle; #301; Rockdale, MD. 21244</b>                               |   |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Park</b>  |  | 20c. Date<br><b>9/26/2000</b>  |   | 20d. Location - City or Town, State<br><b>Elkridge, Maryland</b>  |   |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>M00869 8728 Liberty Road; Randallstown, Maryland 21133</b>   |   |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |   |   |   | Approximate Interval Between Onset and Death                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HUMAN IMMUNODEFICIENCY VIRUS POSITIVE</b>  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
| 28d. Describe how injury occurred   |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |   |   |   |
| 29b. Signature and title of certifier<br><br><b>K.S. RAO M.D.</b>   |  |   |  | 29c. License number<br><b>D 43462</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 22, 00</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K.S. RAO M.D.<br/>NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD</b>  |  |   |  |  |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  |   |  | 32. Registrar's Signature<br>  |   |   |   |   |





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State of Maryland / Department of Health and Mental Hygiene

00 30238

## Certificate of Death

Reg. No.

|   |  |  |   |                                |  |   |  |                                   |  |
|---|--|--|---|--------------------------------|--|---|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Fortunata Mary Holmes  |  |   |                                | 2. Date of Death<br>Month: Sept. 20, Day: 2000 Year: 2000  |   | 3. Time of Death<br>8:00 PM                                      |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Keswick Nursing Home   |  |   |                                | 4b. City, Town, or Location of Death<br>Baltimore  |   | 4c. County of Death<br>N/A                                       |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>579-26-2384   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>95 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>12-5-1904   | 9. Birthplace (State or Foreign Country)<br>PA                   |                                   |  |
|   | Usual Residence of Decedent  |  |   |                                |  |   |  |                                   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Owings Mills   |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |                                   |  |
|   | 10e. Street and Number<br>12326 Bonita Avenue  |  |   | 10f. Zip Code<br>21117         |  | 10g. Citizen of What Country?<br>U.S.A.   |  |                                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Teacher                                     |                                | 16b. Kind of Business/Industry<br>Elementary School's  |   |  |                                   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Castrenze Nigrelli  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emanuella Franco  |   |  |                                   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Suzanne Spohn Daughter   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12326 Bonita Avenue Owings Mills, MD 21117  |   |  |                                   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cem.   |                                | Date<br>9/29/00  |   | 20c. Location - City or Town, State<br>Arlington, Virginia       |                                   |  |
|   | 21. Signature of Funeral Service Licensee<br>Stephen M Jenkins   |  | 22. Name and Address of Facility<br>Eline Funeral Home 21136<br>11824 Reisterstown Road Reisterstown, MD  |                                |  |   |  |                                   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Dementia illness diagnosed as Alzheimer's Disease<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |                                |  |   |  |                                   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |                                |  |   |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |                                |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>Dr. Isabelle MacGregor MD             |   | 29c. License number<br>D13657  |  | 29d. Date signed (Month, Day, Year)<br>September 21, 2000   |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. ISABELLE MACGREGOR, 700 W 40th STREET, BALTIMORE MARYLAND 21211   |  |  |   |                                |  |   |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>SEP 26 2000  |  | 32. Registrar's Signature<br>Benny B Sparks                                    |   |                                |  |   |  |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 30239

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |   |  |  |
|--|---|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LORENA P. HAWKINS</b>                        |   |  |  | 2. Date of Death<br>Month <b>09</b> Day <b>21</b> Year <b>00</b> |   | 3. Time of Death<br><b>4:40 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5121 NELSON AVENUE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>         |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-66-7851</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>40</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                   | 8. Date of Birth (Month, Day, Year)<br><b>12-24-59</b>                                      |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
|  | Usual Residence of Decedent   |   |  |  |  |   |  |  |
| 10a. State<br><b>MD</b>  |   | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>5901 ST. REGIS ROAD</b>   |   |   |  | 10f. Zip Code<br><b>21206</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 TH GRADE</b> College (1-4or 5+) <b>N/A</b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CLERK</b>  |  | 16b. Kind of Business/Industry<br><b>LAW FIRM</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ROBERT HAWKINS</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VIOLA IRBY</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>VIOLA HAWKINS / MOTHER</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5121 NELSON AVE., BALTO. MD. 21215</b>   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>9.25.00 BALTO. MD</b>                             |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>VAUGHN C. GREENE FUNERAL SERVICE<br/>15151 BALTO. NATL PIKE, BALTO. MD. 21229</b>   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Aids</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>MOTHERS HOME</b> |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D20649</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9/22/2000</b>                                     |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6101 N-CHARLES ST., BLDG. 9, STE. 4902, BALTO. MD. 21204</b>  |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   |   |  | 32. Registrar's Signature<br>  |  |   |  |  |

ORIGINAL




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State of Maryland / Department of Health and Mental Hygiene

00 30240

Certificate of Death

Reg. No.

|   |  |   |  |  |   |   |  |  |
|---|--|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Maurice Johnson</b>                                   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Sept. 22, 2000</b> |   | 3. Time of Death<br><b>6:30pm</b>                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Ritchie Hospice Care</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>    |   | 4c. County of Death<br><b>NA</b>                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-58-4552</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br><b>10-03-50</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>                                    |   | 10c. City, Town or Location<br><b>Baltimore</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1321 N. Ensor Street</b>   |  | 10f. Zip Code<br><b>21202</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>1yr.</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Receptionist</b>                  |  | 16b. Kind of Business/Industry<br><b>State of Maryland</b>   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Elmore Johnson</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn M. Elliott</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Bonnie Johnson</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>804 Cliffedge Road Baltimore, Maryland 21208</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Pk. Cem. 09-27-2000 Arbutus, MD</b>                     |  | 20c. Location - City or Town, State  |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202<br/>WM. C. March FH 1101 E. North Avenue</b>  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. <u>Cardiomyopathy</u></b><br>Due to (or as a consequence of):<br><b>b. <u>Renal Failure</u></b><br>Due to (or as a consequence of):<br><b>c. <u>Diabetes</u></b><br>Due to (or as a consequence of):<br><b>d.</b>   |  |   |  |  |   |   |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>23b. Did tobacco use contribute to the cause of death?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br><b>24a. Was an autopsy performed?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>24b. Were autopsy findings available prior to completion of cause of death?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28b. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><br><b>Joseph H. Stephens MD</b>  |  |   |  | 29c. License number<br><b>D 11457</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>Sept 23, 2000</b>                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>1616 Barton St. Baltimore MD 21217 Joseph H. Stephens MD</b>   |  |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  |   |  | 32. Registrar's Signature<br>   |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Amended Item#30 perDVR G787 9/26/2000 EW

00 30241

|  |  |   |  |   |  |  |  |   |
|--|--|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Matilda Jacobson</b>                            |   |  |   | 2. Date of Death<br>Month <b>09</b> Day <b>18</b> Year <b>2000</b> |  | 3. Time of Death<br><b>4:10 pm</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Riverview CARE CENTER</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>           |  | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-09-5706</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.  | If Under 1 Year<br>Months Days                                     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 19, 1916</b>                                     |   |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |   |  |   |  |  |  |   |
| Usual Residence of Decedent  |  |   |  |   |  |  |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>4613 Mannasota Avenue</b>   |  |   |  | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                             |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retail Sales Clerk</b>  |  | 16b. Kind of Business/Industry<br><b>Sales</b>                             |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Andrew Svatey</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Srein</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Albin W. Jacobson-Son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7740 37th Street East, Sarasota FL 34243</b>  |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>   |  | 20c. Location - City or Town, State<br><b>Parkville, MD</b>                |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Evans Funeral Chapel<br/>8800 Harford Rd. Parkville, MD</b>  |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Coronary Vascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. {</b><br><b>c. {</b><br><b>d. {</b> |  |   |  |   |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pneumonia</b><br><b>Demencia</b><br><b>Diabetes</b>   |  |   |  |   |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |   |  |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28d. Describe how injury occurred  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D19667</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>09-21-2000</b>                   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael H. Schwartz 5517 A Ritchie Highway Baltimore, MD 21225</b>  |  |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 00 30242

## Certificate of Death

Reg. No.

|   |   |   |  |   |   |   |  |   |
|---|---|---|--|---|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Donald Wilford Jarrells</b>                      |   |  |   | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>24</b> Year <b>2000</b> |   | 3. Time of Death<br><b>10.16 P.M.</b>      |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>                |   | 4c. County of Death<br><b>Anne Arundel</b> |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>213 34 9195</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 25, 1938</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b> |
|   | Usual Residence of Decedent   |   |  |   |   |   |  |   |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Pasadena</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
| 10e. Street and Number<br><b>219 Asbury Road</b>  |   |   |  | 10f. Zip Code<br><b>21122</b>   |   | 10g. Citizen of What Country?<br><b>U.S.</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>Welder</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bethlehem Steel</b>   |   | 16b. Kind of Business/Industry  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Wilford M. Jarrells</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Evelyn J. Brooks</b>  |   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Evelyn Jarrells / Wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>219 Asbury Road Pasadena, Maryland 21122</b>  |   |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | Date<br><b>9/28/00</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>  |   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Anoxic Encephalopathy</b><br>Due to (or as a consequence of):<br><b>b. STATUS EPILEPTICUS</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>SEVERE CARDIOMYOPATHY</b><br><b>Valvular Heart Disease</b><br><b>Mitral valve replacements.</b><br><b>Coronary Artery Bypass Surgery</b> |   |   |  |   |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SEVERE CARDIOMYOPATHY</b><br><b>Valvular Heart Disease</b><br><b>Mitral valve replacements.</b><br><b>Coronary Artery Bypass Surgery</b>   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 28d. Describe how injury occurred   |   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  | 29a. Certify only one<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |   |
| 29b. Signature and title of certifier<br> M D  |   |   |  | 29c. License number<br><b>DS1245</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 24, 2000</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SAJID SHARIF NORTH ARUNDEL HOSPITAL GLEN BURNIE - MD</b>   |   |   |  |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br>   |  |   |   |   |  |   |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30243

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>FRANCIS GERALD KELLY</b>   |  |  |  | 2. Date of Death<br>Month <b>SEPT</b> Day <b>19</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>5:00 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-16-4999</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 11, 1924</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Linthicum</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>728 Wedeman Ave.</b>  |  | 10f. Zip Code<br><b>21090</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chauffeur</b>  |  | 16b. Kind of Business/Industry<br><b>Exxon Corporation</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Vincent Kelly</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary L. Pentz</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Anna T. Kelly (Wife)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>728 Wedeman Ave. Linthicum, MD 21090</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | 20c. Date<br><b>9/21/00</b>  |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br>   |  |
|   | 22. Name and Address of Facility<br><b>Loudon Park Funeral Home</b><br><b>3620 Wilkins Ave., Baltimore, MD 21229</b>  |  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>INTRA CRANIAL METASTASIS</b><br>Due to (or as a consequence of):<br><br>b. <b>MALIGNANT MELANOMA</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><br><b>7 MONTHS</b><br><br><b>3 YEARS</b>   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|   | 29b. Signature and title of certifier<br><br><b>DR. SANDEEP GAUTAM</b>  |  | 29c. License number<br><b>P13472</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEP 19, 2000</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. SANDEEP GAUTAM, HARBOR HOSPITAL, BALTIMORE, MD 21225</b>   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  | 32. Registrar's Signature<br>  |  | 33. Date of Death (Month, Day, Year)<br><b>SEP 19, 2000</b>   |  | 34. Time of Death (Month, Day, Year)<br><b>5:00 AM</b>  |  |

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State of Maryland / Department of Health and Mental Hygiene

Amended Item#5 perFHG788 10/16/2000 EW

## Certificate of Death

Reg. No.

00 30244

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|---|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Mary Frances Kenney  |  |   |  | 2. Date of Death<br>Month Day Year<br>September 21, 2000   |  |  |  | 3. Time of Death<br>7:03 AM  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>Julia Manor Health Care Center   |  |   |  | 4b. City, Town, or Location of Death<br>Hagerstown   |  |  |  | 4c. County of Death<br>Washington  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>214-16-2819 2813  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>February 21, 1917                             |  | 9. Birthplace (State or Foreign Country)<br>Illinois   |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD   |  | 10b. County<br>Washington   |  | 10c. City, Town or Location<br>Hancock   |  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>275 West Main Street   |  |   |  | 10f. Zip Code<br>21750   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Seamstress  |  |  | 16b. Kind of Business/Industry<br>Clothing Manufacture           |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Jerry Sitar   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Anna Karun  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Anna L. Funk/Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>275 West Main Street Hancock, MD 21750  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Lawn Memorial Park  |  | 20c. Date<br>9/25/2000   |  | 20d. Location - City or Town, State<br>Hagerstown, MD                                |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Grove Funeral Home, P.A.<br>141 W. Main St. Hancock, MD 21750-0368   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. LYMPHOCYTIC LEUKEMIA.<br>Due to (or as a consequence of):<br>b. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>c. CARCINOMA OF GALLBLADDER<br>Due to (or as a consequence of):<br>d. |  |   |  |  |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>URINARY TRACT INFECTION  |  |   |  |  |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| State Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br>DS2323  |  | 29d. Date signed (Month, Day, Year)<br>9/22/00   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Muhammad Waseem 10148 Saint George Cir. Hagerstown, MD 21740   |  |   |  |  |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>SEP 26 2000   |  |   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30245

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|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><u>Mildred M. Kennison</u>   |  |   |  | 2. Date of Death<br>Month <u>September</u> Day <u>23</u> Year <u>2000</u>  |  | 3. Time of Death<br><u>9:00 PM</u>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Fallston General Hospital</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>Fallston</u>  |  | 4c. County of Death<br><u>Harford</u>   |  |
| Funeral<br>Director                              | 5. Social Security Number<br><u>214-20-6960</u>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>74</u> Yrs.   |  | 8. Date of Birth<br>Month <u>March</u> Day <u>17</u> Year <u>1926</u>                       |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>  |  | 10a. State<br><u>Md</u>   |  | 10b. County<br><u>Harford</u>  |  | 10c. City, Town or Location<br><u>Whiteford</u>   |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><u>1407 Old Pylesville Rd</u>   |  | 10f. Zip Code<br><u>21160</u>  |  | 10g. Citizen of What Country?<br><u>USA</u>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>                     |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><u>COOK</u>   |  | 16b. Kind of Business/Industry<br><u>Ballpark Diner</u>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><u>Romey R. Lewis</u>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Hallie McCoy</u>   |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><u>Patricia Cochran - daughter</u>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1407 Old Pylesville Rd. Whiteford, Md 21160</u>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Belt Air Mem. Gdns.</u>  |  | 20c. Location - City or Town, State<br><u>Belt Air Maryland</u>  |  | 20d. Date<br><u>Sept 26 2000</u>  |  |
| To Be Completed by<br>Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><u>Heather J. Wells</u>   |  |   |  | 22. Name and Address of Facility<br><u>Evans Funeral Chapel</u><br><u>3 Newport Dr. Forest Hill, Md 21050</u>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. Hypoxemia</u><br>Due to (or as a consequence of):<br><u>b. Emphysema</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>c.<br>Due to (or as a consequence of):<br><br>d. |  |   |  | Approximate Interval Between Onset and Death<br><u>2 days</u><br><u>5 years</u>  |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by<br>Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  | 29b. Signature and title of certifier<br><u>Phu MD</u>   |  | 29c. License number<br><u>DS3462</u>  |  |
| To Be Completed by<br>Physician/Medical Examiner | 29d. Data signed (Month, Day, Year)<br><u>9/24/00</u>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Jude C. Moneses, MD</u><br><u>7845 Oakwood Road Glen Burnie, MD 21061</u>  |  |  |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><u>SEP 26 2000</u>  |  | 32. Registrar's Signature<br><u>Bennett Sparks</u>  |  |  |  |   |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

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|--|---|-----------------------------------|---|--|--|--|--|--|---|---|----|-----------------------------------|--|----|----------------------------|----|--|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>MARY M. Keene</i>                                  |                                   |   |  |  | 2. Date of Death<br>Month <i>Sept</i> Day <i>24</i> Year <i>2000</i> |  | 3. Time of Death<br><i>645pm</i>   |   |   |    |                                   |  |    |                            |    |  |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Mariner Health - Bel Air</i> |                                   |   |  |  | 4b. City, Town, or Location of Death<br><i>Bel Air</i>               |  | 4c. County of Death<br><i>Harford</i>  |   |   |    |                                   |  |    |                            |    |  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>215-22-9067</i>   |                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>74</i> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth<br>Month <i>Sept</i> Day <i>23</i> Year <i>1926</i>                           |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |   |    |                                   |  |    |                            |    |  |    |  |
|  | Usual Residence of Decedent   |                                   |   |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 10a. State<br><i>Md</i>  |   | 10b. County<br><i>Harford</i>     |   | 10c. City, Town or Location<br><i>Belt Air</i>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 10e. Street and Number<br><i>1111 Glasterbury Way</i>  |   |                                   |   |  | 10f. Zip Code<br><i>21014</i>  |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   |                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)  |   |                                   |   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>secretary</i>  |  |  | 16b. Kind of Business/Industry<br><i>Baltimore County Police Dep.</i>  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 17. Father's Name (First, Middle, Last)<br><i>Bernard J. Prevost</i>   |   |                                   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Isabel R. Heiblin</i>  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><i>KEVIN K. Keene SON</i>  |   |                                   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1111 Glasterbury Way Bel Air, Md 21014</i>   |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Highview Cemetery</i>  |  |  | 20c. Location - City or Town, State<br><i>2000 Fallston Md</i>       |  | 20d. Date<br><i>Sept 28</i>  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 21. Signature of Funeral Service Licensed<br><i>Kerita L Wells</i>   |   |                                   |   |  | 22. Name and Address of Facility<br><i>EVANS FUNERAL Chapel<br/>3 Newport Dr. Forest Hill, Md 21050</i>  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |                                   |   |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><i>Cerebral Vascular Accident</i></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <i>2 wks</i><br/><br/> <i>years</i> </td> </tr> <tr> <td>b.</td> <td><i>Atrial Fibrillation</i></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |                                   |   |  |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <i>Cerebral Vascular Accident</i> | Approximate Interval Between Onset and Death<br><br><i>2 wks</i><br><br><i>years</i> | b. | <i>Atrial Fibrillation</i> | c. |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.  | <i>Cerebral Vascular Accident</i> | Approximate Interval Between Onset and Death<br><br><i>2 wks</i><br><br><i>years</i>  |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
|  | b.  | <i>Atrial Fibrillation</i>        |   |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
|  | c.  |                                   |   |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
|  | d.  |                                   |   |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |    |                                   |  |    |                            |    |  |    |  |
|  |   |                                   |   |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |    |                                   |  |    |                            |    |  |    |  |
|  |   |                                   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |    |                                   |  |    |                            |    |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                                   | 28a. Date of Injury (Month, Day Year)<br><i>NA</i>  |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                           |   |    |                                   |  |    |                            |    |  |    |  |
|  |   |                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |    |                                   |  |    |                            |    |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                                   |   |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 29b. Signature and title of certifier<br><i>Chris Ar MD</i>  |   |                                   |   |  | 29c. License number<br><i>D 39889</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>September 25, 2000</i>                               |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>ALFRED SPARKS 615 W. MacPherson Bel Air MD 21014</i>  |   |                                   |   |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br><i>SEP 26 2000</i>  |   |                                   | 32. Registrar's Signature<br><i>Alfred Sparks</i>   |  |  |  |  |  |   |   |    |                                   |  |    |                            |    |  |    |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

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State of Maryland / Department of Health and Mental Hygiene

00 30247

## Certificate of Death

Reg. No.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Alexander John Kolego                             |   | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 19, 2000  |  | 3. Time of Death<br>11:23 PM                              |
|  | 4a. Facility Name (If not institution, give street and number)<br>Saint Joseph Medical Center |   | 4b. City, Town, or Location of Death<br>Towson  |  | 4c. County of Death<br>Baltimore                          |
| Funeral<br>Director  | 5. Social Security Number<br>218-40-7523  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>58 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                            |
|  | 8. Date of Birth (Month, Day, Year)<br>April 28, 1942   |   | 9. Birthplace (State or Foreign Country)<br>Mt. Carmel, PA.   |  |   |
| Usual Residence of Decedent  |   |   |   |  |   |
| 10a. State<br>Maryland   |   | 10b. County<br>Baltimore Co.  |   | 10c. City, Town or Location<br>Towson  |   |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |   |
| 10e. Street and Number<br>903 Starbit Road   |   |   | 10f. Zip Code<br>21286  |  | 10g. Citizen of What Country?<br>United States of America |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Vietnam   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 04   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales/Consultant   |   | 16b. Kind of Business/Industry<br>Financial Services   |   |
| 17. Father's Name (First, Middle, Last)<br>George Kolego   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gertrude Shupinski   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Timothy A. Kreft (Brother In Law)  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14 Independence Drive New Freedom, PA. 17349 |  |   |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial Gardens   |   | 20c. Location - City or Town, State<br>Timonium, Maryland  |   |
| 21. Signature of Funeral Service Licensee<br>Jeffrey L. Gair   |   | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204-2515  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |   |
| Immediate Cause (Final disease or condition resulting in death)  |   |   |   |  |   |
| a. CARDIAC ARRYTHMIA   |   |   |   |  |   |
| Due to (or as a consequence of):   |   |   |   |  |   |
| b. CORONARY ARTERY DISEASE   |   |   |   |  |   |
| Due to (or as a consequence of):   |   |   |   |  |   |
| c.   |   |   |   |  |   |
| Due to (or as a consequence of):   |   |   |   |  |   |
| d.   |   |   |   |  |   |
| Approximate Interval Between Onset and Death<br>1 HOUR   |   |   |   |  |   |
| MONTHS   |   |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |   |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |   |
| 29b. Signature and title of certifier<br>A. J. Helou, M.D.   |   | 29c. License number<br>D 17695  |   | 29d. Date signed (Month, Day, Year)<br>September 19, 2000  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ABDALLAH J. HELOU, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21206   |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br>SEP 26 2000   |   | 32. Registrar's Signature<br>Benjamin S. Harris   |   |  |   |

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified in accordance with the law.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

SEPTEMBER 14 1950

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

30248

|   |  |                                 |   |   |   |  |                                |  |   |  |   |  |  |
|---|--|---------------------------------|---|---|---|--|--------------------------------|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Cosimina Anna Liberto</i>                 |                                 |   |   | 2. Date of Death<br>Month Day Year<br><i>September 25, 2000</i> |  |                                |  | 3. Time of Death<br><i>4:00 AM</i>                                      |  |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>9008 Tammy Road</i> |                                 |   |   | 4b. City, Town, or Location of Death<br><i>Baltimore</i>        |  |                                |  | 4c. County of Death<br><i>Baltimore</i>                                 |  |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>216-18-4595</i>  |                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><i>76</i> Yrs.                |  | If Under 1 Year<br>Months Days |  | 8. Date of Birth (Month, Day, Year)<br><i>Sept. 14, 1924</i>            |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i> |  |  |
|   | Usual Residence of Decedent  |                                 |   |   |   |  |                                |  |   |  |   |  |  |
| 10a. State<br><i>Maryland</i>   |  | 10b. County<br><i>Baltimore</i> |   | 10c. City, Town or Location<br><i>Baltimore</i>   |   |  |                                |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><i>3901 Hannon Court, Apt. 1B</i>   |  |                                 |   | 10f. Zip Code<br><i>21236</i>   |   |  |                                | 10g. Citizen of What Country?<br><i>U.S.A.</i>                                   |   |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>10th Grade</i> College (1-4 or 5+)  |  |                                 |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Seamstress</i>  |   |  |                                | 16b. Kind of Business/Industry<br><i>Tie Maker</i>                               |   |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Joseph Manfre</i>   |  |                                 |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Serafina Lamartina</i>   |                                |  |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Mr. Cosimo J. Liberto (son)</i>  |  |                                 |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>510 Cesky Place, Bel Air, MD 21014</i>   |                                |  |   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                 |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>St. Joseph Church Cem.</i>   |   |  |                                | Date<br><i>9/27/00</i>   |   | 20c. Location - City or Town, State<br><i>Baltimore, Maryland</i>                              |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Bruce A. Miller</i>   |  |                                 |   |   |   | 22. Name and Address of Facility<br><i>Schimunek Funeral Home, Inc.<br/>9705 Belair Rd., Baltimore, MD 21236</i>   |                                |  |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                                 |   |   |   |  |                                |  |   |  |   | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)   |  |                                 |   |   |   |  |                                |  |   |  |   | <i>3 DAYS</i>  |  |
| Due to (or as a consequence of):<br><i>a. ASPIRATION PNEUMONIA</i>  |  |                                 |   |   |   |  |                                |  |   |  |   |  |  |
| Due to (or as a consequence of):<br><i>b. PROGRESSIVE OVARIAN CARCINOMA</i>   |  |                                 |   |   |   |  |                                |  |   |  |   | <i>7 YEARS</i>   |  |
| Due to (or as a consequence of):<br><i>c.</i>   |  |                                 |   |   |   |  |                                |  |   |  |   |  |  |
| Due to (or as a consequence of):<br><i>d.</i>   |  |                                 |   |   |   |  |                                |  |   |  |   |  |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                 |   |   |   |  |                                |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                 |   |   |   |  |                                |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                 |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Daughter's Residence</i> |   |  |                                |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |                                 |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |                                |  |   |  |   |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                 |   |   |   |  |                                |  |   |  |   |  |  |
| 29b. Signature and title of certifier<br><i>William P. McAnis, MD</i>   |  |                                 |   |   |   | 29c. License number<br><i>D16801</i>   |                                |  | 29d. Date signed (Month, Day, Year)<br><i>9/26/00</i>                   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>301 ST. PAUL PL BALTIMORE, MD 21202</i>  |  |                                 |   |   |   |  |                                |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>SEP 26 2000</i>   |  |                                 |   | 32. Registrar's Signature<br><i>Benita B. Smith</i>   |   |  |                                |  |   |  |   |  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30249

|  |  |  |   |                                |   |  |  |   |
|--|--|--|---|--------------------------------|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PAULETTE A. LANE</b>  |  |   |                                | 2. Date of Death<br>Month Day Year<br><b>SEPT. 16 2000</b>  |  | 3. Time of Death<br><b>6:20 AM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>C HESAPEAKE HOSPICE</b>   |  |   |                                | 4b. City, Town, or Location of Death<br><b>LINTHICUM</b>  |  | 4c. County of Death<br><b>A.A. COUNTY</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-44-0311</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>JAN 10, 1944</b> |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |
|  | Usual Residence of Decedent  |  |   |                                |   |  |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>A.A. COUNTY</b>   |                                | 10c. City, Town or Location<br><b>PASADENA</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>7849 WILLING COURT</b>  |  |   |                                | 10f. Zip Code<br><b>21122</b>   |  | 10g. Citizen of What Country?<br><b>USA.</b>   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9TH GRADE</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STEAMSTRESS</b>                   |                                | 16b. Kind of Business/Industry<br><b>DRY CLEANERS</b>   |  |  |   |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM DORSEY</b>   |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JEANETTE BRADY</b>  |  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>HILDA DORSEY (STEP-MOTHER)</b>  |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7319 DOTSON LANE, GLEN BURNIE, MD. 21060</b>  |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HALLS U.M.C. CEMETERY</b>  |                                | 20c. Location - City or Town, State<br><b>9-23-00 GLEN BURNIE, MD.</b>  |  | 20d. Date  |   |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME<br/>2140 N. FULTON AVE., BALTO. MD. 21217</b>                             |                                |   |  |  |   |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>metastatic Vulvar cancer</b>   |  |   |                                |   |  |  |   |
|  | Immediate Cause (Final disease or condition resulting in death)<br><b>3 months</b>   |  |   |                                |   |  |  |   |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Due to (or as a consequence of):</b><br><b>Due to (or as a consequence of):</b><br><b>Due to (or as a consequence of):</b><br><b>Due to (or as a consequence of):</b> |  |   |                                |   |  |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |   |  |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |                                | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>                             |  |   |                                | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |   |
|  | 28a. Date of Injury (Month, Day Year)  |  |   |                                | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
| State Registrar  | 28d. Describe how injury occurred  |  |   |                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |
|  | 29b. Signature and title of certifier<br>  |  |   |                                | 29c. License number<br><b>D39041</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>September 18th 2000</b>                              |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>G. NIMMAGADDA 3001 S. Hanover Street Baltimore MD 21225</b> |  |  |   |                                |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  |  |   | 32. Registrar's Signature<br>  |   |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 00 30250

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |   |
|---|---|--|---|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Ronald Paul Lipinski</u>   |  |   |  | 2. Date of Death<br>Month <u>September</u> Day <u>23</u> Year <u>2000</u>  |  | 3. Time of Death<br><u>12:15am</u>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>VAMHS Fort Howard Division</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>Fort Howard</u>   |  | 4c. County of Death<br><u>Baltimore</u>  |   |
| Funeral<br>Director                           | 5. Social Security Number<br><u>215486181</u>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>50</u> Yrs.  | If Under 1 Year<br>Months <u>  </u> Days <u>  </u> | If Under 24 Hrs.<br>Hours <u>  </u> Min. <u>  </u>   | 8. Date of Birth (Month, Day, Year)<br><u>Dec. 11, 1949</u>                                    |  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u> |
|   | Usual Residence of Decedent   |  |   |  |  |  |  |   |
| To Be Completed by Funeral Director           | 10a. State<br><u>Md.</u>  | 10b. County<br><u>Baltimore</u>  | 10c. City, Town or Location<br><u>Parkville</u>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
|   | 10e. Street and Number<br><u>3138 DuBois Ave.</u>   |  |   | 10f. Zip Code<br><u>21234</u>                      |  | 10g. Citizen of What Country?<br><u>USA</u>  |  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>  </u> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>  </u> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>          |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>  </u>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired).<br><u>truck driver</u>                           |  | 16b. Kind of Business/Industry<br><u>produce com.</u>  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><u>Stanley A. Lipinski, Sr.</u>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Genovieve Fialkowski</u>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Stanley A. Lipinski, Sr.</u>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3138 DuBois Ave. Parkville, Md 21234</u>   |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>  </u>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Parkwood Cemetery</u>  |  | 20c. Location - City or Town, State<br><u>2000 Parkville, Md.</u>  |  | 20d. Date<br><u>Sept. 26</u>   |   |
|   | 21. Signature of Funeral Service Licensee<br><u>Krista L. Wells</u>   |  | 22. Name and Address of Facility<br><u>Evans Funeral Chapel</u><br><u>8800 Harford Rd. Baltimore, Md 21234</u>  |  |  |  |  |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |   |
|   | Immediate Cause (Final disease or condition resulting in death)   |  |   |  |  |  |  |   |
|   | a. <u>Metastatic Pancreatic Cancer</u><br>Due to (or as a consequence of):  |  |   |  |  |  |  |   |
|   | b. <u>  </u><br>Due to (or as a consequence of):  |  |   |  |  |  |  |   |
| To Be Completed by Physician/Medical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |  |  |  |   |
|   | c. <u>  </u><br>Due to (or as a consequence of):  |  |   |  |  |  |  |   |
|   | d. <u>  </u><br>Due to (or as a consequence of):  |  |   |  |  |  |  |   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Intestinal Obstruction</u>   |  |   |  |  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |  |   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |   |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |  |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>  </u>   |  |   |  |  |  |  |   |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><u>  </u>   |  | 28b. Time of Injury<br><u>M</u>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |
|   | 28d. Describe how injury occurred<br><u>  </u>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><u>  </u>   |  |  |  |  |   |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><u>  </u>   |  |   |  |  |  |  |   |
| To Be Completed by Physician/Medical Examiner | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |   |
|   | 29b. Signature and title of certifier<br><u>George C. Wicks III M.D.</u>  |  |   |  | 29c. License number<br><u>D41365</u>   |  | 29d. Date signed (Month, Day, Year)<br><u>September 23, 2000</u>                 |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>George Wicks, MD 9600 North Point Rd, Fort Howard, MD 21052</u>  |  |   |  |  |  |  |   |
|   | 31. Date filed (Month, Day, Year)<br><u>SEP 26 2000</u>   |  | 32. Registrar's Signature<br><u>Benita B. Sparks</u>  |  |  |  |  |   |

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 30251

|   |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Vincent Michael Lucantoni  |  |   |  | 2. Date of Death<br>Month Day Year<br>September 20, 2000   |  | 3. Time of Death<br>10:00PM   |  |   |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>3334 Garnet Rd.  |  |   |  | 4b. City, Town, or Location of Death<br>Parkville  |  | 4c. County of Death<br>Baltimore                                    |  |   |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>212-20-2808   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>75 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Jul 19, 1925                 |  |   |  |  |  |  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10. Usual Residence of Decedent<br>10a. State<br>MD   |  | 10b. County<br>Baltimore   |  | 10c. City, Town or Location<br>Parkville                            |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>3334 Garnet Road  |  | 10f. Zip Code<br>21234   |  | 10g. Citizen of What Country?<br>U.S.A.                             |  |   |  |  |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br>White |  |   |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Supvs. of electricians                   |  | 16b. Kind of Business/Industry<br>Baltimore City Dep. of Education   |  |   |  |   |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Theodore Lucantoni  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Ida Tolucci   |  |   |  |   |  |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Marie F. Lucantoni   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3334 Garnet Road, Baltimore, MD 21234   |  |   |  |   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |  | 20c. Location - City or Town, State<br>Parkville, MD   |  | 20d. Date<br>Sep 23 2000  |  |   |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Kevin B. Wells</i>   |  |   |  | 22. Name and Address of Facility<br>Evans Funeral Chapel<br>8800 Harford Rd. Parkville, MD   |  |   |  |   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Approximate Interval Between Onset and Death  |  |   |  |  |  |   |  |   |  |  |  |  |  |
|   | <table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)<br/><br/>                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a. <u>Cardiomyopathy</u><br/>Due to (or as a consequence of):</td> <td rowspan="4">                 Approximate Interval Between Onset and Death<br/><br/> <u>Years</u> </td> </tr> <tr> <td>b. <u>Atherosclerotic Cardiovascular Disease</u><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. <br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. <br/>Due to (or as a consequence of):</td> </tr> </table> |  |   |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>Cardiomyopathy</u><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br><u>Years</u> | b. <u>Atherosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of): | c.<br>Due to (or as a consequence of): | d.<br>Due to (or as a consequence of): |
|   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a. <u>Cardiomyopathy</u><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br><u>Years</u>  |  |  |  |   |  |   |  |  |  |  |  |
| b. <u>Atherosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| c.<br>Due to (or as a consequence of):  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| d.<br>Due to (or as a consequence of):  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Renal failure</u>  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Alan Halle</i><br>29c. License number<br>041614<br>29d. Date signed (Month, Day, Year)<br>September 22, 2000  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr Alan Halle 4920 Campbell Rd. White Marsh Md  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 26 2000<br>32. Registrar's Signature<br><i>Benjamin B. Sparks</i>  |  |  |   |  |  |  |   |  |   |  |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30252

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Francis Leyh

2. Date of Death

Month Day Year  
SEPTEMBER 20, 2000 10:15 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

220-20-1298

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 31, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3103 Pinewood Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 46-48

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Baltimore City  
Police Department

17. Father's Name (First, Middle, Last)

John Wolfgang Leyh

18. Mother's Name (First, Middle, Maiden Surname)

Mary O'Brien

19a. Informant's Name/Relationship (Type, Print)

Nellie Leyh-Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3103 Pinewood Avenue, Baltimore, Maryland 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cemetery

Date

Sep 25  
2000

20c. Location - City or Town, State

Garrison, MD

21. Signature of Funeral Service Licensee

Stephanie A.

22. Name and Address of Facility

Evans Funeral Chapel  
8800 Harford Rd. Parkville, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEVERE HYPOXEMIA

Approximate Interval Between Onset and Death

2 WEEKS

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

MODERATE TO SEVERE TRICUSPID REGURGITATION

WEEKS

Due to (or as a consequence of):

PULMONARY ARTERY HYPERTENSION

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Carcinoma

Status Post Coronary Artery Bypass Grafts

Atherosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Steven R. Axe M.D.

29c. License number

D 34543

29d. Date signed (Month, Day, Year)

9/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN R. AXE, M.D., 7601 OSLER DRIVE TOWSON, MARYLAND 21204

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Steven R. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30253

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Harry Calvin Lehneis  |  |  |  | 2. Date of Death<br>Month Day Year<br>September 23, 2000   |  |  |  | 3. Time of Death<br>1:35 P.M.          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Multi Medical Center  |  |  |  | 4b. City, Town, or Location of Death<br>Towson   |  |  |  | 4c. County of Death<br>Baltimore Co.   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>216-14-8617  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>78 Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.         |  |
|   | 8. Date of Birth<br>(Month, Day, Year)<br>June 12, 1922   |  | 9. Birthplace (State or Foreign Country)<br>Baltimore, Maryland  |  | 10a. State<br>Maryland   |  | 10b. County<br>Harford Co.   |  | 10c. City, Town or Location<br>Belcamp |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>4407 Sophia's Way  |  | 10f. Zip Code<br>21017   |  | 10g. Citizen of What Country?<br>United States of America                    |  |  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: W.W.II   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White             |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | College (1-4 or 5+)<br>n/a   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Supervisor  |  | 16b. Kind of Business/Industry<br>Westinghouse                               |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Christian Lehneis, Sr.   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Kate Smith  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print) (Wife)<br>Mrs. Jennie Harding (nee Parks) Lehneis  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4407 Sophia's Way Belcamp, Maryland 21017   |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrison Forest Veteran's Cem.   |  | Date<br>9/27/2000  |  | 20c. Location - City or Town, State<br>Owings Mills, Maryland                |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Jeffrey L. Gair  |  |  |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Atherosclerotic Coronary Artery Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |  |  | Approximate Interval Between Onset and Death<br>hours<br>years   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Stroke<br>Carcinoma of prostate   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M               |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br>[Signature] Attending   |  |  |  | 29c. License number<br>D17118          |  |
|   | 29d. Date signed (Month, Day, Year)<br>Sept 25, 2000  |  |  |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Paul Schwartz, M.D. 115 East Melrose Ave. Baltimore, Maryland 21212   |  |  |  |  |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>SEP 26 2000  |  |  |  | 32. Registrar's Signature<br>[Signature]   |  |  |  |  |  |

ORIGINAL



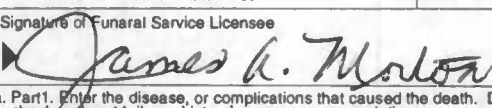
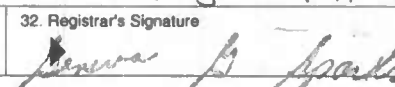
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30254

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>SYLVIA VERNETTA LEACOCK</b>  |  |   |  | 2. Date of Death<br>Month <b>9</b> Day <b>22</b> Year <b>00</b>   |  | 3. Time of Death<br><b>5:30 A</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HERITAGE HARBOUR HEALTH &amp; REHAB CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>  |  | 4c. County of Death<br><b>AACO.</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>132-16-4696</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>96</b>   |  | 8. Date of Birth (Month, Day, Year)<br><b>06-06-04</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>BARBADOS</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3400 GULLEY RD.</b>  |  | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAMSTRESS</b>  |  | 16b. Kind of Business/Industry<br><b>CLOTHING</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>AUGUSTUS ALKINS</b>   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>LOUISE CHASE</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>FERDINAND LEACOCK, MD/SON</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3400 GULLEY RD., BALTIMORE MD. 21215</b>  |  |
| Physician<br>/Medical<br>Examiner             | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHRIST CHURCH</b>  |  | Date<br><b>9/30/2000</b>  |  | 20c. Location - City or Town, State<br><b>CHRIST CHURCH PARISH BARBADOS</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>JAMES A. MORTON &amp; SONS F.H., INC<br/>1701 LAURENS ST. BALTO., MD. 21217</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>a. <b>coronary Artery disease</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |  | Approximate Interval Between Onset and Death<br><b>Yrs.</b>   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury M</b><br><b>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b><br><b>28d. Describe how injury occurred</b><br><b>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b> |  |
| State Registrar                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>1541978</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9-22-2000</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Nader Sawakhi MD. 1 Hosp Chevy Chase MD. 20785</b>   |  | 31. Date filed (Month, Day, Year)<br><b>SEP 25 2000</b>   |  | 32. Registrar's Signature<br>  |  |   |  |











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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

00 30256

Reg. No.

|  |   |   |  |  |  |  |   |  |
|--|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOSEPH EARL MOORE JR.</b>                                  |   |  |  | 2. Date of Death<br>Month Day Year<br><b>9/25/2000</b>     |  | 3. Time of Death<br><b>11:30 AM</b>                   |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>(HOME) 5715 EDMONDSON AVE. (AA2)</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>CATONSVILLE</b> |  | 4c. County of Death<br><b>BALTO.</b>                  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220 20 4571</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>5/27/29</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>  |   | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>BALTO.</b>                               |  | 10c. City, Town or Location<br><b>CATONSVILLE</b>     |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>5715 EDMONDSON AVE. (AA2)</b>  |  | 10f. Zip Code<br><b>21228</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>AFRO AMERICAN</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>                  |  | 16b. Kind of Business/Industry<br><b>L. GORDON &amp; SONS</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>EARL MOORE</b>   |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BLANCH HALL</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Lillian MOORE</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5715 EDMONDSON AVE. CATONSVILLE, MD. 21228</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST</b>   |   | 20c. Location - City or Town, State<br><b>10/2/2000 OWINGS MILLS MD.</b>  |  | 21. Signature of Funeral Service Licensee<br><i>Paula Stup</i>   |  | 22. Name and Address of Facility<br><b>ESTEP BROTHERS FUNERAL HOME P.A.<br/>1300 EUTAW PL. BALTO. MD. 21217</b>  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hydrocephalus</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>1.5 Years</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |  |
| 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Michael G. Sparks, MD</i>  |   |  |
| 29c. License number<br><b>D50727</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>9/26/2000</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael G. Sparks 900 Caton Ave, Baltimore, MD 21229</b>  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   |  |
| 32. Registrar's Signature<br><i>Paula Stup</i>   |   | 33. State Registrar   |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020  |  | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30257

|  |   |  |   |                                |  |  |   |
|--|---|--|---|--------------------------------|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES WILLIAM MOULTRIE SR.</b>   |  | 2. Date of Death<br>Month <b>09</b> Day <b>23</b> Year <b>2000</b>  |                                | 3. Time of Death<br><b>1:55 AM</b>   |  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>2608 ROSLYN AVENUE</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death<br><b>NIA</b>  |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>250-42-2657</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>AUG. 23, 1933</b> | 9. Birthplace (State or Foreign Country)<br><b>SOUTH CAROLINA</b>                           |
|  | Usual Residence of Decedent   |  | 10a. State<br><b>MARYLAND</b>   |                                | 10b. County<br><b>NIA</b>  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>           |   |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2608 ROSLYN AVENUE</b>   |                                | 10f. Zip Code<br><b>21216</b>  |  | 10g. Citizen of What Country?<br><b>USA.</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |
| To Be Completed by Physician/Medical Examiner  | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9TH GRADE</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>BUS OPERATOR</b>   |                                | 16b. Kind of Business/Industry<br><b>MTA.</b>  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>WILLIAM MOULTRIE</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname) <b>UNKNOWN</b>  |                                |  |  |   |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>EILEEN MOULTRIE (WIFE)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2608 ROSLYN AVE, BALTIMORE, MD. 21216</b>   |                                |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST</b>  |                                | 20c. Date<br><b>9-28-00</b>  |  | 20d. Location - City or Town, State<br><b>OWINGS MILLS, MD.</b>                             |
| To Be Completed by Physician/Medical Examiner  | 21. Signature of Funeral Service Licensee<br><b>John Williams</b>   |  | 22. Name and Address of Facility<br><b>JOSEPH H. BROWN JR. FUNERAL HOME<br/>2140 N. FULTON AVE. BALTIMORE, MD. 21217</b>  |                                |  |  |   |
|  | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>BRAIN TUMOR</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>BRAIN TUMOR</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>5 MONTHS</b>   |                                |  |  |   |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                                |  |  |   |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                |  |  |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |   |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |  |  |   |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>John Williams M.D.</b>  |                                |  |  |   |
|  | 29c. License number<br><b>RES-000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 25, 2000</b>  |                                |  |  |   |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARCUS BROWN, M.D.<br/>JOHNS HOPKINS HOSPITAL 600 N. WOLFE STREET BALTIMORE, MARYLAND 21287</b>  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |                                |  |  |   |
|  | 32. Registrar's Signature<br><b>per [Signature] Sparks</b>  |  | 33. Registrar's Signature<br><b>per [Signature] Sparks</b>  |                                |  |  |   |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30258

|  |   |   |   |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>CRESTON JAMES MILLS, SR</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>SEPT. 24, 2000</b>  |  | 3. Time of Death<br><b>10:50am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>ST. AGNES NURSING &amp; REHAB CENTER</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>ELLCOTT CITY</b>  |  | 4c. County of Death<br><b>HOWARD</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-01-8580</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 9, 1911</b>                                    |  |
|  | Usual Residence of Decedent   |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10. City, Town or Location<br><b>BALTIMORE</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MARYLAND</b>   |   | 10b. County   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>5168 STAFFORD ROAD</b>   |   |   |  | 10f. Zip Code<br><b>21229</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CAPTAIN</b>                       |  | 16b. Kind of Business/Industry<br><b>BALTIMORE CITY FIRE DEPARTMENT</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JAMES GARFIELD MILLS</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA S. EMIG</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>CRESTON J. MILLS, JR. (SON)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5905 DALE DRIVE, ELDERSBURG, MD 21784</b>  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY</b>   |  | Date<br><b>9/27/00</b>   |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>                              |  |
|  | 21. Signature of Funeral Service Licensee   |   |   |  | 22. Name and Address of Facility<br><b>LOUDON PARK FUNERAL HOME</b><br><b>3620 WILKINS AVE., BALTIMORE, MARYLAND 21229</b>   |  |  |  |
|  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Gangrene right leg</b><br>Due to (or as a consequence of):<br>b. <b>Peripheral Vascular Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>2 mo</b><br><b>5 yrs</b> |   |   |  |  |  |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Diabetes Mellitus<br>Arterio Sclerotic heart disease  |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b><br><b>Arterio Sclerotic heart disease</b>   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Baskaran</b>   |   |   |   | 29c. License number<br><b>D21649</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 25, 2000</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sambandam Baskaren, M.D. 3455 Wilkens Ave, Baltimore, MD 21229</b>  |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30259

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CLIFFORD L. MCKENZIE</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPT 23 2000</b>  |  | 3. Time of Death<br><b>4:22 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL HOSPITAL COLUMBIA</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>  |  | 4c. County of Death<br><b>HOWARD</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-30-0160</b>  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB 15, 1932</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Elkridge</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>6539 Vaile Drive</b>  |  | 10f. Zip Code<br><b>21075</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>   |  | 16b. Kind of Business/Industry<br><b>Building Maintenance</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>George Thomas McKenzie</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bertie Matilda Mongold</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jo-Ann Louise McKenzie/wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6539 Vaile Drive Elkridge, MD 21075</b>  |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>   |  | 20c. Date<br><b>9/25/00</b>  |  | 20d. Location - City or Town, State<br><b>Baltimore, MD</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Dawn F. McDonald</b>   |  |
|   | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br>b. <b>lung cancer</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br><b>1 year</b> |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                 |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day, Year)<br><b>SEP 20 2000</b>   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>MAI-CHI NGUYEN, MD, FCCP</b>   |  |
|   | 29c. License number<br><b>D36845</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Sept 24, 2000</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MAI-CHI NGUYEN, MD, FCCP<br/>7350 Grace Drive, Columbia, MD 21044</b>   |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>Benjamin A. Sparks</b>   |  | 33. Date of Death (Month, Day, Year)<br><b>SEP 23 2000</b>   |  | 34. Date of Death (Month, Day, Year)<br><b>SEP 23 2000</b>   |  | 35. Date of Death (Month, Day, Year)<br><b>SEP 23 2000</b>   |  |

ORIGINAL

James T. McHugh

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30260

|   |   |   |   |  |   |  |                                     |
|---|---|---|---|--|---|--|-------------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Charles Hamden Mead, Sr.                    |   |   |  | 2. Date of Death<br>Month Day Year<br>SEPT 22, 2000 |  | 3. Time of Death<br>9:10am          |
|   | 4a. Facility Name (If not institution, give street and number)<br>700 Chesapeake Avenue |   |   |  | 4b. City, Town, or Location of Death<br>Annapolis   |  | 4c. County of Death<br>Anne Arundel |
| Funeral<br>Director   | 5. Social Security Number<br>549-24-6383  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>93 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Birth (Month, Day, Year)<br>JULY 6, 1907  |                                     |
|   | 9. Birthplace (State or Foreign Country)<br>California                                  |   |   |  |   |  |                                     |
| Usual Residence of Decedent   |   |   |   |  |   |  |                                     |
| 10a. State<br>Maryland  |   | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Annapolis   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                     |
| 10e. Street and Number<br>700 Chesapeake Avenue   |   |   |   | 10f. Zip Code<br>21403   |   | 10g. Citizen of What Country?<br>USA   |                                     |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1940-1960   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                                     |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |   |   |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Captain   |   | 16b. Kind of Business/Industry<br>US Navy  |                                     |
| 17. Father's Name (First, Middle, Last)<br>Ernest Eugene Mead   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nora Noble  |   |  |                                     |
| 19a. Informant's Name/Relationship (Type, Print)<br>Tarrant H. Lomax/Personal Rep.  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>700 Chesapeake Avenue Annapolis, MD 21403   |   |  |                                     |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.   |   | Date<br>9/23/00  |   | 20c. Location - City or Town, State<br>Baltimore, MD   |                                     |
| 21. Signature of Funeral Service Licensee<br>Dawn F. McDonald   |   |   |   | 22. Name and Address of Facility<br>Cremation Society of Maryland, Inc.<br>299 Frederick Road Baltimore, MD 21228  |   |  |                                     |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |   |  |                                     |
| Immediate Cause (Final disease or condition resulting in death)<br>e. Prostate cancer<br>Due to (or as a consequence of):   |   |   |   |  |   |  |                                     |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):   |   |   |   |  |   |  |                                     |
| c. Due to (or as a consequence of):   |   |   |   |  |   |  |                                     |
| d. Due to (or as a consequence of):   |   |   |   |  |   |  |                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                     |
|   |   |   |   |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                     |
|   |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                     |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |                                     |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                     |
| 28d. Describe how injury occurred   |   |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |                                     |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |   |  |                                     |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |   |  |                                     |
| 29b. Signature and title of certifier<br>John Dannerberger MD   |   |   |   | 29c. License number<br>038324  |   | 29d. Date signed (Month, Day, Year)<br>9/22/00   |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>John Dannerberger MD 600 Ridgely Ave Annapolis MD 21401   |   |   |   |  |   |  |                                     |
| 31. Date filed (Month, Day, Year)<br>SEP 26 2000  |   | 32. Registrar's Signature<br>Sparks   |   |  |   |  |                                     |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30261

|   |  |                                       |   |   |  |  |  |  |
|---|--|---------------------------------------|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>RITA M. MILLER                       |                                       |   |   | 2. Date of Death<br>Month Day Year<br>SEPT. 20 2000  |  | 3. Time of Death<br>1:30am   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1023 UPNOR RD. |                                       |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director   | 5. Social Security Number<br>213-12-3851   |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>05/17/1921  |  |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND                             |                                       |   |   |  |  |  |  |
| Usual Residence of Decedent   |  |                                       |   |   |  |  |  |  |
| 10a. State<br>MD  |  | 10b. County<br>N/A                    |   | 10c. City, Town or Location<br>BALTIMORE  |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 10e. Street and Number<br>1023 UPNOR RD.  |  |                                       |   | 10f. Zip Code<br>21212  |  | 10g. Citizen of What Country?<br>USA   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12YRS<br>College (1-4 or 5+)   |  |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOUSEWIFE  |  | 16b. Kind of Business/Industry<br>HOMEMAKER  |  |  |
| 17. Father's Name (First, Middle, Last)<br>JOSEPH J. FELL   |  |                                       |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY CATHERINE MOORE   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>RITA MILLER (DAUGHTER)  |  |                                       |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1023 UPNOR RD. BALTO., MD. 21212.  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>NEW CATHEDRAL   |   | Date<br>09/23/2000   |  | 20c. Location - City or Town, State<br>BALTO., MD.   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                       |   | 22. Name and Address of Facility<br>HENRY W. JENKINS & SONS CO.<br>4905 YORK RD. BALTO., MD. 21212.   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CARCINOMA OF LUNG<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                       |   |   |  |  |  | Approximate Interval Between Onset and Death<br>5 Months   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HYPERTENSION  |  |                                       |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|   |  |                                       |   |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|   |  |                                       |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                                       |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                       |   |   |  |  |  |  |
| 29b. Signature and Title of certifier<br>   |  |                                       |   | 29c. License number<br>D25686   |  | 29d. Date signed (Month, Day, Year)<br>9-20-00                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>EBRAHIM IPAKCHI M.D. 7600 OSLER DRIVE TOWSON, MD. 21204.  |  |                                       |   |   |  |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>SEP 26 2000                                 |                                       |   |   | 32. Registrar's Signature<br>  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene 00 30262

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>NORMA ELIZABETH MUNGER   |   |   | 2. Date of Death<br>Month Day Year<br>Sept. 24, 2000  |  | 3. Time of Death<br>9:35 PM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Towson  |   |   | 4b. City, Town, or Location of Death<br>Towson  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director  | 5. Social Security Number<br>215-18-6892   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Apr. 2, 1921   | 9. Birthplace (State or Foreign Country)<br>Md.  |  |  |
|  | Usual Residence of Decedent  |   |   |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Md.  | 10b. County<br>Baltimore  | 10c. City, Town or Location<br>Towson   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
|  | 10e. Street and Number<br>105 Kenilworth Park Dr. Apt. 1-B   |   |   | 10f. Zip Code<br>21204  |  | 10g. Citizen of What Country?<br>USA   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Home maker                               |   | 16b. Kind of Business/Industry<br>Own home   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>John Lester Mintines  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Catherine F. Rosendorn   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Ms. Deborah K. Jackson/daughter  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8400 Arroyo Pl. Baltimore, Md. 21234 |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.   |   | 20c. Location - City or Town, State<br>Towson, Md.   |  |  |
|  | 21. Signature of Funeral Service Licensee  |   | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204   |   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |  |
|  | <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. CARCINOMA OF THE COLON 1-2 yrs</p> <p>b. METASTASES TO THE LUNG 3 MONTH</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> |   |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE   |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |   |   |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br>Walter R. Welzant MD  |  | 29c. License number<br>1D12039  |   | 29d. Date signed (Month, Day, Year)<br>9/25/00  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Walter R. Welzant, M.D. 7600 Osler Dr. Suite 107 Towson, Md. 21204   |  |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 26 2000   |  | 32. Registrar's Signature<br>Sharon A. Sparks   |   |   |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30263

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Pierce Molesworth

2. Date of Death

Month Day Year  
September 24, 2000 2:51 am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

212-03-2789

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 4, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10535 Warren Place Apt. 301

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: '43-'4613. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
n/a16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Regional Sales Manager

16b. Kind of Business/Industry

Food

17. Father's Name (First, Middle, Last)

Charles Molesworth

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Vernay

19a. Informant's Name/Relationship (Type, Print)

Susan Tearle/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7903 Shore Rd., Balto., MD 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

9/26/00

20c. Location - City or Town, State

Timonium, MD 21093

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home  
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Lung Cancer

Due to (or as a consequence of):

2 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Brian J. Bohner MD

29c. License number

D 0043489

29d. Date signed (Month, Day, Year)

9/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian J. Bohner, M.D. 6569 N. Charles St., Suite 601, Towson, MD 21204

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

30264

|   |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Catherine E. Nelka</b>  |  |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>24</b> Year <b>2000</b>   |  |  |  | 3. Time of Death<br><b>1:35 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Charlestown Retirement Community Care Center Catonsville</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-16-4581</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>03/19/1923</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
|   | Usual Residence of Decedent  |  |  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>                       |  | 10c. City, Town or Location<br><b>Severn</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>8146 Harvest Ct.</b>   |  |  |  | 10f. Zip Code<br><b>21144</b>  |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>   |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b> College (14 or 5+) <b>College</b>   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Office Manager</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Wholesale Distribution</b>   |  |  |  | 17. Father's Name (First, Middle, Last)<br><b>Frank Mucha</b>  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Rajs</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Christine Nelka / Daughter</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19724 Selby Avenue Poolesville, Maryland 20837</b>   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>entombment</b>   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  |  |  | 20c. Location - City or Town, State<br><b>9/28/00 Baltimore, Maryland</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Kathleen Weber CFSP</b>  |  |  |  | 22. Name and Address of Facility<br><b>David J. Weber Funeral Homes, P.A.<br/>5311 Edmondson Avenue Baltimore, Maryland 21229</b>   |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>DEMENTIA</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |
|   | 28a. Date of Injury (Month, Day, Year)   |  |  |  | 28b. Time of injury<br><b>M</b>   |  |  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br><b>Blair J. Nantz M.D.</b>   |  |  |  | 29c. License number<br><b>D44748</b>   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>September 25, 2000</b>   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MATTHEW J. Nantz 711 MAIDEN CHOICE LANE CATONSVILLE, MD 21228</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  |
|   | 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>   |  |  |  |   |  |  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene 00 30265

## Certificate of Death

Reg. No.

|  |   |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
|--|---|--|--|--------------------------------|--|---|--|---|--|--|---------------|--|---------------|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Violet House Norwood</b>   |  | 2. Date of Death<br>Month <b>Sept.</b> Day <b>24th</b> Year <b>2000</b>  |                                | 3. Time of Death<br><b>4:19 AM</b>   |   |  |   |  |  |               |  |               |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Carroll County General Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>   |                                | 4c. County of Death<br><b>Carroll</b>  |   |  |   |  |  |               |  |               |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-34-1697</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.   | If Under 1 Year<br>Months Days | 8. Date of Birth (Month, Day, Year)<br><b>June 17 1903</b>   |   |  |   |  |  |               |  |               |    |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10. Usual Residence of Decedent  |                                |  |   |  |   |  |  |               |  |               |    |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Md.</b>  | 10b. County<br><b>Carroll County</b>                                       | 10c. City, Town or Location<br><b>Gamber</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |               |  |               |    |  |
|  | 10e. Street and Number<br><b>4607 London Bridge Road</b>  |  | 10f. Zip Code<br><b>21784</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |   |  |  |               |  |               |    |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |   |  |  |               |  |               |    |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>               |                                |  |   |  |   |  |  |               |  |               |    |  |
| To Be Completed by Physician/Medical Examiner  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Home Owner</b>  |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>John William Wroten</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Jane Willingham</b>  |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Douglas Norwood (Son)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4607 London Bridge Road, Gamber, Md. 21784</b> |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |                                | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |   |  |   |  |  |               |  |               |    |  |
| To Be Completed by Physician/Medical Examiner  | 21. Signature of Funeral Service Licensee<br><b>Richard Pickett</b>   |  | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home P.A.<br/>130 E. Fort Ave. Baltimore, Md. 21230</b>                            |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | <table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Aspiration Pneumonia</b><br/>Due to (or as a consequence of):</td> <td>Approximate Interval Between Onset and Death<br/><b>2 days</b></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. <b>Right Cerebral Vascular Accident</b><br/>Due to (or as a consequence of):</td> <td><b>2 days</b></td> </tr> <tr> <td>c. <b>Cerebral Edema</b><br/>Due to (or as a consequence of):</td> <td><b>2 days</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |  |                                |  | Immediate Cause (Final disease or condition resulting in death) | a. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><b>2 days</b> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>Right Cerebral Vascular Accident</b><br>Due to (or as a consequence of): | <b>2 days</b> | c. <b>Cerebral Edema</b><br>Due to (or as a consequence of): | <b>2 days</b> | d. |  |
|  | Immediate Cause (Final disease or condition resulting in death)   | a. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):         | Approximate Interval Between Onset and Death<br><b>2 days</b>  |                                |  |   |  |   |  |  |               |  |               |    |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>Right Cerebral Vascular Accident</b><br>Due to (or as a consequence of):  | <b>2 days</b>  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | c. <b>Cerebral Edema</b><br>Due to (or as a consequence of):  | <b>2 days</b>  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | d.  |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                     |   |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
| To Be Completed by Physician/Medical Examiner  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
| To Be Completed by Physician/Medical Examiner  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |                                | 28b. Time of Injury<br><b>M</b>  |   |  |   |  |  |               |  |               |    |  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 28e. Place of Injury: At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |   |  |   |  |  |               |  |               |    |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.   |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
| State Registrar  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D37494</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>Sept. 24th 2000</b>  |   |  |   |  |  |               |  |               |    |  |
|  | 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)<br><b>Alexander Brylachevsky, 245 Stoner Ave, Westminster, MD, 21157</b>   |  |  |                                |  |   |  |   |  |  |               |  |               |    |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>                            |  |                                |  |   |  |   |  |  |               |  |               |    |  |

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State of Maryland / Department of Health and Mental Hygiene

00 30266

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |   |   |   |
|---|--|---|--|---|---|---|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WALLACE NICHOLS</b>                                 |   |  |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 22, 00</b> |   | 3. Time of Death<br><b>9:55AM</b>       |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST HOSPITAL CENTER</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>   |   | 4c. County of Death<br><b>BALTIMORE</b> |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>221-10-9908</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 13, 1922</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Delaware</b> |
|   | Usual Residence of Decedent  |   |  |   |   |   |   |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Randallstown</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
| 10e. Street and Number<br><b>3511 Stoneybrook Road</b>  |  |   |  | 10f. Zip Code<br><b>21133</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>   |   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>-0-</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesman</b>  |   | 16b. Kind of Business/Industry<br><b>Retail</b>   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Clarence Nichols</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys Cornelia Stewart</b>   |   |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Sabina T. Nichols - Wife</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3511 Stoneybrook Road; Randallstown, Maryland 21133</b>   |   |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gdns.</b>  |   | 20c. Location - City or Town, State<br><b>9/25/00 Timonium, Maryland</b>  |   |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.</b><br><b>8728 Liberty Road; Randallstown, Maryland 21133</b>   |   |   |   |   |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>DIABETES</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |   |   |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES</b>   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |
| 28d. Describe how injury occurred   |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |   |   |   |   |
| 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>043462</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 22, 00</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>K.S. RAO, M.D.</b><br><b>NORTHWEST HOSPITAL CENTER RANDALLSTOWN, MD</b>  |  |   |  |   |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  |   |  | 32. Registrar's Signature<br>   |   |   |   |   |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30267

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|---|--|--|--|--|---|--|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>JOHN RICHARD OARE, SR.                             |  |  |  | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 21, 2000  |  | 3. Time of Death<br>10:25 AM  |  |  |  |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>2809 KINGS RIDGE ROAD APT. C |  |  |  | 4b. City, Town, or Location of Death<br>PARKVILLE   |  | 4c. County of Death<br>BALTIMORE  |  |  |  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-03-6312   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (in yrs. last birthday)<br>81 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>06/06/19   |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  |  |   |  |
|   | Usual Residence of Decedent  |  |  |  |   |  |   |  |  |  |  |   |  |
| 10a. State<br>MD  |  |  | 10b. County<br>BALTIMORE   |  |   | 10c. City, Town or Location<br>PARKVILLE   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |   |  |
| 10e. Street and Number<br>2809 KINGS RIDGE RD. APT. C   |  |  |  |  | 10f. Zip Code<br>21234  |  |   | 10g. Citizen of What Country?<br>USA   |  |  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>8TH GRADE   |  |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CONTRACTOR   |  |   | 16b. Kind of Business/Industry<br>HOME BUILDING                              |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>CHARLES RICHARD OARE   |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY HELEN MOORE   |  |   |  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>ANNA C. OARE WIFE   |  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2809 KINGS RIDGE RD. APT. C. BALTIMORE, MD 21234   |  |   |  |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>METRO CREMATORY, INC.  |  |   | 20c. Location - City or Town, State<br>CATONSVILLE, MD   |   | 20d. Date<br>9/25/00   |  |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Heath N. Hays</i>   |  |  |  |  | 22. Name and Address of Facility<br>THE JOHNSON FUNERAL HOME, P.A.<br>8521 LOCH RAVEN BLVD. TOWSON, MD 21286  |  |   |  |  |  |  |   |  |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Renal Failure<br>Due to (or as a consequence of):<br>b. Congestive Heart Failure<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
|   |  |  |  |  |   |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |  |   |  |
|   |  |  | 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)   |  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  | 29b. Signature and title of certifier<br><i>Frank H. Morris</i>   |  |   |  |  | 29c. License number<br>D0018406  |  | 29d. Date signed (Month, Day, Year)<br>9-21-00  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>FRANK MORRIS 7505 OSIER DR TOWSON MD 21204  |  |  |  |  |   |  |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>SEP 26 2000  |  |  |  |  | 32. Registrar's Signature<br><i>Benita B. Sparks</i>  |  |   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

00 30268

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |   |   |  |
|---|--|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE PURNELL</b>                            |   |  |  | 2. Date of Death<br>Month <b>SEPT</b> Day <b>24</b> Year <b>2000</b> |   | 3. Time of Death<br><b>11:50 AM</b>                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>BON SECURE HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |   | 4c. County of Death<br><b>NA</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-34-3849</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.                     |   | 8. Date of Birth<br>Month <b>DECEMBER</b> Day <b>6</b> Year <b>1938</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>                         |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>1206 N. EDEN STREET</b>  |  | 10f. Zip Code<br><b>21213</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify <b>AFRICAN AMERICAN</b>           |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b> College (1-4or 5+) <b>NA</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>WELDER - LABORER</b>              |  | 16b. Kind of Business/Industry<br><b>CITY</b>  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>GEORGE NEWTON</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ISABELLE JOHNSON</b>   |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>KAREN PURNELL - DAUGHTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1724 KENWELL STREET SAN DIEGO, CA. 92139</b>   |  |   |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | 20c. Location - City or Town, State<br><b>9/29/00 RANDALLSTOWN, MD</b>   |  |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>WYLIE FUNERAL HOME P A</b><br><b>638 N. GILMOR STREET BALTIMORE, MD 21217</b>   |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Anoxic Encephalopathy</b><br>Due to (or as a consequence of):<br><b>b. Cardio pulmonary Arrest</b><br>Due to (or as a consequence of):<br><b>c. Delirium Tremens</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D26256</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/24/2000</b>  |  |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BICIT DUONG 1940 W. Baltimore St Baltimore MD 21223</b>  |  |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  | 32. Registrar's Signature<br>   |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30269

## Certificate of Death

Reg. No.

|   |   |                           |   |   |  |  |  |  |
|---|---|---------------------------|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALICE PARKER</b>                                       |                           |   |   | 2. Date of Death<br>Month <b>Sept</b> Day <b>22</b> Year <b>00</b>   |  | 3. Time of Death<br><b>5:30 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MILLENNIUM HEALTH OF LIBERTY</b> |                           |   |   | 4b. City, Town, or Location of Death<br><b>Balto City</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-30-7184</b>   |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>01-26-07</b>   | 9. Birthplace (State or Foreign Country)<br><b>HARFORD, CTY</b>  |
|   | Usual Residence of Decedent   |                           |   |   |  |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10a. Street and Number<br><b>1825 W. MOSHER ST</b>  |   |                           |   | 10f. Zip Code<br><b>21216</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                               |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)  |   |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWORK</b>   |  | 16b. Kind of Business/Industry<br><b>DOMESTIC</b>                            |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ALFRED WITTINGTON</b>   |   |                           |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELLA TASCO</b>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>GEORGIA J. PAYNE, DAUGHTER</b>   |   |                           |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1909 CHELSA RD, BALTIMORE, MD 21216</b>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL</b>   |  | 20c. Location - City or Town, State<br><b>9/27/00 ARBUTUS, MARYLAND</b>      |  |  |
| 21. Signature of Funeral Service Licensee<br><b>William E. Howell</b>   |   |                           |   | 22. Name and Address of Facility<br><b>HOWELL FUNERAL HOME<br/>4600 LIBERTY HIGHTS AVE, BALTO. MD 21207</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |                           |   |   |  |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)   |   |                           |   |   |  |  |  |  |
| a. <b>Coronary artery disease</b> years   |   |                           |   |   |  |  |  |  |
| Due to (or as a consequence of):  |   |                           |   |   |  |  |  |  |
| b. <b>Atherosclerotic cardiovascular disease</b> years  |   |                           |   |   |  |  |  |  |
| Due to (or as a consequence of):  |   |                           |   |   |  |  |  |  |
| c. <b>disease</b>   |   |                           |   |   |  |  |  |  |
| Due to (or as a consequence of):  |   |                           |   |   |  |  |  |  |
| d. <b>H/O Congestive heart failure</b>  |   |                           |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Recent Abuse</b><br><b>Knee Amputation (L)</b>   |   |                           |   |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |                           |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                           |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                           |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |                           |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   |   |                           |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                           |   | 29b. Signature and title of certifier<br><b>Amatun H. Maqem MD</b>  |  |  |  |  |
|   |   |                           |   | 29c. License number<br><b>D15503</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/22/00</b>                        |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>AMATUN H. MAQEM, 501 Dolphin St Balto MD 21217</b>   |   |                           |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   |                           |   | 32. Registrar's Signature<br><b>Benjamin A. Sparks</b>  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30270

AMEND#10E PER F.H. G787 9-28-2000 JAB

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>BARBARA E. PARSONS</b>  |  |  |  | 2. Date of Death<br>Month: <b>SEPTEMBER</b> Day: <b>21<sup>st</sup></b> Year: <b>2000</b>   |  | 3. Time of Death<br><b>10:55 AM</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Levindale Hebrew Geriatric Center</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-28-9254</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F             |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 16, 1922</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>England</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Woodlawn</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>3304 Keston Road</b>   |  | 10f. Zip Code<br><b>21207</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <b>12</b> College (1-4 or 5+):                    |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Time Keeper</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Retail Store</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>William Pascall</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ada Elizabeth Lowe</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret Talbott (Daughter)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3343 Keswick Road Baltimore, MD 21211</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veteran's</b>   |  | 20c. Location - City or Town, State<br><b>Garrison Forest, MD</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Lynn B. Henss</b>  |  |  |  | 22. Name and Address of Facility<br><b>Burgee-Henss-Seitz Funeral Home, Inc.<br/>3631 Falls Road, Baltimore, Maryland</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>4 months</b>   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br><b>Donna M. Cuenley M.D.</b>   |  | 29c. License number<br><b>D 54739</b>   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 21<sup>ST</sup> 2000</b>   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>2434 W Belvedere Avenue, Baltimore Maryland 21215</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  |  |  | 32. Registrar's Signature<br><b>Donna M. Cuenley</b>  |  |   |  |
|   | State Registrar  |  |  |  |   |  |   |  |



### Certificate of Death

Reg. No. 00 3027

Physician  
/Medical  
Examiner

**Funeral Director**

**Baltimore, Maryland 21215-0020**

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

## To Be Completed by Funeral Director

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Josephine E. Piereman</b>  |  | 2. Date of Death<br>Month <b>Sept.</b> Day <b>24</b> Year <b>2000</b>   |   | 3. Time of Death<br><b>4:10AM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Eldercare Hammonds Lane</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>Anne Arundel</b>   |  |
| 5. Social Security Number<br><b>212 74 3498</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.   |  |
|   |  | If Under 1 Year<br>Months Days  |   | If Under 24 Hrs.<br>Hours Min.   |  |
|   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 19, 1901</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Glen Burnie</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 10a. Street and Number<br><b>8075 Solley Avenue</b>   |  | 10f. Zip Code<br><b>21060</b>   |   | 10g. Citizen of What Country?<br><b>U.S.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th</b>   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>College (1-4 or 5+)  |  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Schultz</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Kosier</b> |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Joran / Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8096 Solley Road Glen Burnie, Maryland 21060</b>  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park</b>   |   | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>  |  |
| 20d. Date<br><b>9/27/00</b>   |  |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>  |   |  |  |
| 23e. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.<br>Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. DEMENTIA</b><br>Due to (or as a consequence of):<br><b>b. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b>   |  |   |   |  |  |
| Approximate Interval Between Onset and Death<br><b>5 years</b>  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |  |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D 21776</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 25 2000</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wanda MUNDRA MD 3001 S Hanover ST Baltimore 21225</b>  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  | 32. Registrar's Signature<br>   |   |  |  |

**Division of Vital Records, P.O. Box 68760,**

**To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

**Medical Certification: To Be Completed by Physician/Medical Examiner**

**State  
Registrar**



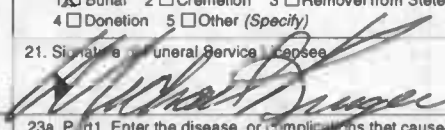
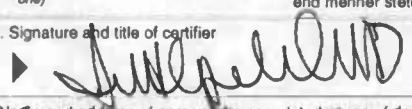

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30272

|   |   |  |  |  |   |
|---|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ERMA PRESSMAN</b>                                |  | 2. Date of Death<br>Month <b>SEPT</b> Day <b>23</b> Year <b>2000</b> |  | 3. Time of Death<br><b>3:25AM</b>       |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1450 BEDFORD AVE. #316</b> |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |  | 4c. County of Death<br><b>BALTIMORE</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-09-4477</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.                     | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.          |
|   | 8. Date of Birth (Month, Day, Year)<br><b>FEB 9 1918</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                |  |   |
| Usual Residence of Decedent   |   |  |  |  |   |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |   |
| 10e. Street and Number<br><b>1450 BEDFORD AVE #316</b>  |   | 10f. Zip Code<br><b>21208</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   |  |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>HERMAN BLINCHIKOFF</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BERTHA KATZEN</b>  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SYLVIA SANDLER/DAUGHTER</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16 AUTUMN WIND CT. REISTERSTOWN, MD. 21136</b>   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BETH EL MEMORIAL PARK</b>   |  | 20c. Location - City or Town, State<br><b>9/24/00 RANDALLSTOWN, MD.</b>  |   |
| 21. Signature of Funeral Service Representative<br>   |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS. INC.<br/>8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)   |   | a. <b>CEREBRAL VASCULAR ACCIDENT</b><br>Due to (or as a consequence of):   |  |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   | b. Due to (or as a consequence of):  |  |  |   |
|   |   | c. Due to (or as a consequence of):  |  |  |   |
|   |   | d. Due to (or as a consequence of):  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinsonism</b>   |   |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   |
|   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |   |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |   |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>027034</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 24, 2000</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Hank Copeland 1838 green TREE Road Baltimore MD 21208</b>  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br>  |  |  |   |

10/10/10 10/10/10 10/10/10 10/10/10

10/10/10 10/10/10 10/10/10 10/10/10

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30273

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alma Pinkney

2. Date of Death

September 21 2000

3. Time of Death

4:35 PM

4a. Facility Name (If not institution, give street and number)

Union Mem. Hosp.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

7/4

Funeral  
Director

5. Social Security Number

249-36-6296

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

3-28-1915

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

md

10b. County

7/4

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2525 N. Asquith Street

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

9th Grade

College (1-4 or 5+)

7/4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Labor

16b. Kind of Business/Industry

Factory Work

17. Father's Name (First, Middle, Last)

Alfred Davis

18. Mother's Name (First, Middle, Maiden Surname)

Rezink Green

19a. Informant's Name/Relationship (Type, Print)

Rezink Roberts

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1423 Kithmore Rd. Balt. Md. 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wesley AME Ch. Cem. 9/28/2000

Date

20c. Location - City or Town, State

Shalerville S.C.

21. Sign

Funeral Service License

22. Name and Address of Facility

Batts Funeral Home  
1129 N. Caroline St. Balt. Md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebral Vascular Accident

10 days

Due to (or as a consequence of):

b. Cerebral Vascular Atherosclerotic Disease

50 years

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coagulopathy  
Cholecystitis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Lightfoot MD

29c. License number

AT2438946A14

29d. Date signed (Month, Day, Year)

September 21 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Lightfoot 201 East University Parkway Baltimore MD 21218

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Spaw

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Marcus Maurice Robinson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30274

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marcus Maurice Robinson

2. Date of Death

Month Day Year  
September 23, 2000

3. Time of Death

9:50 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4529 St. George's Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

214-51-9016

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

17 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Oct 6, 1982

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Balt.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2524 Druid Park Dr.

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Student

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

Robert Bernard Robinson

18. Mother's Name (First, Middle, Maiden Surname)

Joyce Duckley

19a. Informant's Name Relationship (Type, Print)

Joyce Robinson Robert Robinson parent

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2524 Druid Park Dr. Balt. Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carrison Forest Vt. Cem. 9/28/2000 Balt. Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Carlton E. Douglas

22. Name and Address of Facility

Carlton E. Douglas Funeral Service  
1701 McCulloh St. Balt. Md. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INTRACRANIAL GUNSHOT WOUND

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☒ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

9/23/00

28b. Time of Injury

9:45 AM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT SHOT SELF

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4529 ST. GEORGE'S AVE. BALTIMORE, MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J.M. T...

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 24, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JACK M. T... M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

EP 26 2000

32. Registrar's Signature

...

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #17 PER INFORMANT G788 State of Maryland / Department of Health and Mental Hygiene  
AMEND ITEM: 1 PER PHY G788 EW

## Certificate of Death

Reg. No.

00 30275

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last) <b>NORMA WALLIS REID</b><br><del>NORMA WALLACE REID</del>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 20, 2000</b>  |  | 3. Time of Death<br><b>7:52PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MARYLAND GENERAL HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>222-01-4838</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>06-07-1910</b>                             |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>                                 |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>2211 WEST ROGERS AVENUE</b>  |  | 10f. Zip Code<br><b>21209</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4 YEARS</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CORPORATE TREASURER</b>             |  | 16b. Kind of Business/Industry<br><b>CORPORATION</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last) <b>SEVERN TEACKLE WALLIS, JR.</b><br><del>SEVERN TEACKLE WALLACE, JR.</del>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BESSIE WHARTON</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT J. MILLER (ATTORNEY)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>901 DULANEY VALLEY RD., TOWSON, MD., 21204</b>   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CREMATORY</b>  |  | 20c. Location - City or Town, State<br><b>9-22 BALTIMORE, MD. 21202</b>  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>HENRY W. JENKINS AND SONS COMPANY</b><br><b>4905 YORK ROAD, BALTIMORE, MARYLAND, 21212</b>  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>SEPSIS</b><br>a. Due to (or as a consequence of):<br><b>MULTI ORGAN FAILURE</b><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |   |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how Injury occurred   |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br><b>89376</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 21, 2000</b>                     |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LETHA JAYAKRISHMAN, M.D., 827 Linden Avenue, BALTO., MD., 21201</b>  |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  |   |  | 32. Registrar's Signature<br>   |  |  |  |
|   | State Registrar   |  |   |  |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30276

|  |  |   |  |   |   |   |   |   |  |
|--|--|---|--|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Veronica Teresa Ryan</b>  |   |  |   | 2. Date of Death<br>Month <b>September</b> Day <b>23</b> Year <b>2000</b> |   | 3. Time of Death<br><b>2<sup>30</sup> P.</b>            |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>North Arundel Hospital 301 Hospital Drive</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Glen Burnie</b>                |   | 4c. County of Death<br><b>Ann Arundel</b>               |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>103-14-5400</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                          |   | 8. Date of Birth (Month, Day, Year)<br><b>3/19/1925</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>  |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Harmans</b>           |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>3 Hanford Drive</b>  |   | 10f. Zip Code<br><b>21077</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                               |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                       |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>John J. Plunkett</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Harmon</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathleen Tennant - daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 6088 Santa Fe, NM 87502</b>  |   |   |   |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Bay View Crematory</b>   |  | Date<br><b>9/27/00</b>  |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>   |   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Kelly Gregory Fink</b>   |  | 22. Name and Address of Facility<br><b>FINK FUNERAL HOME, PA<br/>426 Crain Hwy., SW, Glen Burnie, MD 21061</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Malignant Pleural Effusion</b><br>Due to (or as a consequence of):<br>b. <b>Non-Small Cell Carcinoma of lung</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |   | Approximate Interval Between Onset and Death<br><b>1 month.</b><br><b>1 year.</b>   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive Lung Disease</b><br><b>Renal Insufficiency</b><br><b>Anemia</b>   |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No              |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>and manner stated.   |   | 29b. Signature and Title of certifier <b>Attending Physician</b>  |   | 29c. License number<br><b>D 44973</b>                                     |  |
| 29d. Date signed (Month, Day, Year)<br><b>September 23 2000</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gurmeet S. Sawhney MD, 325 Hospital Drive, 202, Glen Burnie MD 21061</b> |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br><b>B. Sparks</b>   |   |   |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30277

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN RICH

2. Date of Death

Month

Day

Year

9

24

00

3. Time of Death

5<sup>15</sup> AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

219-03-1526

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 13, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1127 Ellicott Driveway

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Afro-American

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Piece Worker

16b. Kind of Business/Industry

Blind Industries

17. Father's Name (First, Middle, Last)

Albert Madison

18. Mother's Name (First, Middle, Maiden Surname)

Pigeon Johnson

19a. Informant's Name/Relationship (Type, Print)

Ms. Celestine Doyle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1127 Ellicott Driveway Balto. Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Mem. Park

Date

9/27/2000

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part 1: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF THE COLON

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. 1

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LIVER METASTASE

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Douglas Ross, MD

29c. License number

D0026327

29d. Date signed (Month, Day, Year)

09/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOUGLAS D. ROSS, MD, 6114 CAMPBELL, COLUMBIA, MD 21045

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 30278

## Certificate of Death

Reg. No.

|  |  |  |  |   |  |  |  |   |
|--|--|--|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Charles L. Righter</b>                            |  |  |   | 2. Date of Death<br>Month Day Year<br><b>September 22, 2000</b>  |  | 3. Time of Death<br><b>306 PM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>Baltimore City</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-30-0446</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>8-29-1934</b>  |   |
|  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>5901 Yorkwood Road</b>  |  |  |  | 10f. Zip Code<br><b>21239</b>   |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>               |  |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1957-1958</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Worker</b>   |  | 16b. Kind of Business/Industry<br><b>J. H. Hampshire</b>       |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Henry Righter</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Louise Barbara Rayman</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. James R. Righter (Brother)</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2400 Lady Margaret Court, Monkton, Maryland 21111</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b> |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Wallace S. Brooks Jr.</b>  |  |  |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road, Towson, Md. 21204</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Respiratory failure</b><br>Due to (or as a consequence of):<br>b. <b>Large exudative left pleural effusion</b><br>Due to (or as a consequence of):<br>c. <b>Probable Lung Cancer</b><br>Due to (or as a consequence of):<br>d. <b></b> |  |  |  | Approximate Interval Between Onset and Death<br><b>48 hours</b><br><b>2 weeks</b>   |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Iron Deficiency Anemia</b><br><b>Sepsis</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day Year)<br><b></b>  |  | 28b. Time of Injury<br><b>M</b>                                |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b></b>  |  |  |  | 28d. Describe how injury occurred<br><b></b>  |  |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>  |  |  |  |   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  | 29b. Signature and title of certifier<br><b>Thomas S. Wilson</b>  |  |  |  |   |
| 29c. License number<br><b>D40277</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>September 22, 2000</b>  |  |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Thomas S. Wilson MD 5601 Loch Raven Blvd Baltimore MD 21239</b>   |  |  |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |  |  |  | 32. Registrar's Signature<br><b>Benita B. Sparks</b>  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30279

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CAROLYN SPRUELL</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 18 2000</b>   |  | 3. Time of Death<br><b>1630 hrs</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>NORTHWEST HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>RANDAUSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-32-3060</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 22, 1938</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>WOODLAWN</b>  |  |
| To Be Completed by Funeral Director                                       | 10e. Street and Number<br><b>7906 DUNHILL VILLAGE</b>  |  | 10f. Zip Code<br><b>21244</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| To Be Completed by Physician/Medical Examiner                             | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12th grade</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>CHARLES VERNON TAYLOR</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EFFIE MOSE</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>SHARON KEARSON / Daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6657 SPRING MILL CIRCLE BALTIMORE, MD 21207</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>  |  | 20c. Location - City or Town, State<br><b>WOODLAWN, MD</b>  |  | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  | 22. Name and Address of Facility<br><b>CHATHAM - HARRIS Funeral Home<br/>5240 REISTERSTOWN ROAD<br/>BALTIMORE, MD 21215</b>   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE MASSIVE PULMONARY EMBOLISM</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><b>9/22/2000</b>   |  |
|   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| State Registrar   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><b>C. Navi MD</b>  |  | 29c. License number<br><b>D37333</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 18, 2000</b>  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>C. NAVI MD, MHC, BALTO. MD 21133</b>  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |   |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30280

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

TYRONE

2. Date of Death

SEPTEMBER 21 2000

3. Time of Death

1635

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

215-88-1888

6. Sex

M 20 F

7. Age (In yrs. last birthday)

24 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct 10, 1975

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

Yes 2 No

10e. Street and Number

3003 WYLLIE AVE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

STUDENT

16b. Kind of Business/Industry

College

17. Father's Name (First, Middle, Last)

TYRONE V. STEPHENS

18. Mother's Name (First, Middle, Maiden Surname)

REUB BURRIS

19a. Informant's Name/Relationship (Type, Print)

REUB STEPHENS / MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3003 WYLLIE AVE BALTIMORE, MD 21215

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

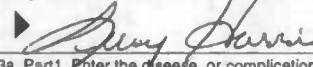
20b. Place of Disposition (Name of cemetery, crematory or other place)

FARMERS MEMORIAL PARK 9-27-2000 HANOVER, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

QUANTICO - HARRIS F.N. 5240 REISTERSTOWN RD BALTIMORE, MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC OSTEOSARCOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

 b. Due to (or as a consequence of):  
 c. Due to (or as a consequence of):  
 d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

 Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

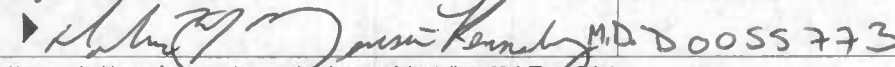
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D0055773

29d. Date signed (Month, Day, Year)

SEPTEMBER 21 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DEBRA M. OENSEN-KENNEDY, 600 NORTH WALFORD STREET, BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature


State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30281

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM SMITH

2. Date of Death

September 20, 2000

3. Time of Death

4:26 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Sinai Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

250 20 6247

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Mar. 30, 1924

9. Birthplace (State or Foreign Country)

Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3616 Park HEIGHTS Ave

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MILL WRIGHT

16b. Kind of Business/Industry

Koppers Mills

17. Father's Name (First, Middle, Last)

HECTOR SMITH

18. Mother's Name (First, Middle, Maiden Surname)

CANDICE FLOYD

19a. Informant's Name/Relationship (Type, Print)

Jean Smith / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3616 Park HEIGHTS Ave Baltimore, Md

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DAVID RIDGE Cemetery

Date

9/25/00

20c. Location - City or Town, State

Pikesville, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CHATHAM - HARRIS Funeral Home  
5240 REISTERSTOWN RD  
BALTIMORE, Maryland 21215

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Embolism

Approximate Interval Between Onset and Death

30 min.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic lung cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

September 20, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Henry Tan, Sinai Hospital of Baltimore, 2401 West Belvedere Ave, Baltimore, MD 21215

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

[Signature]

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

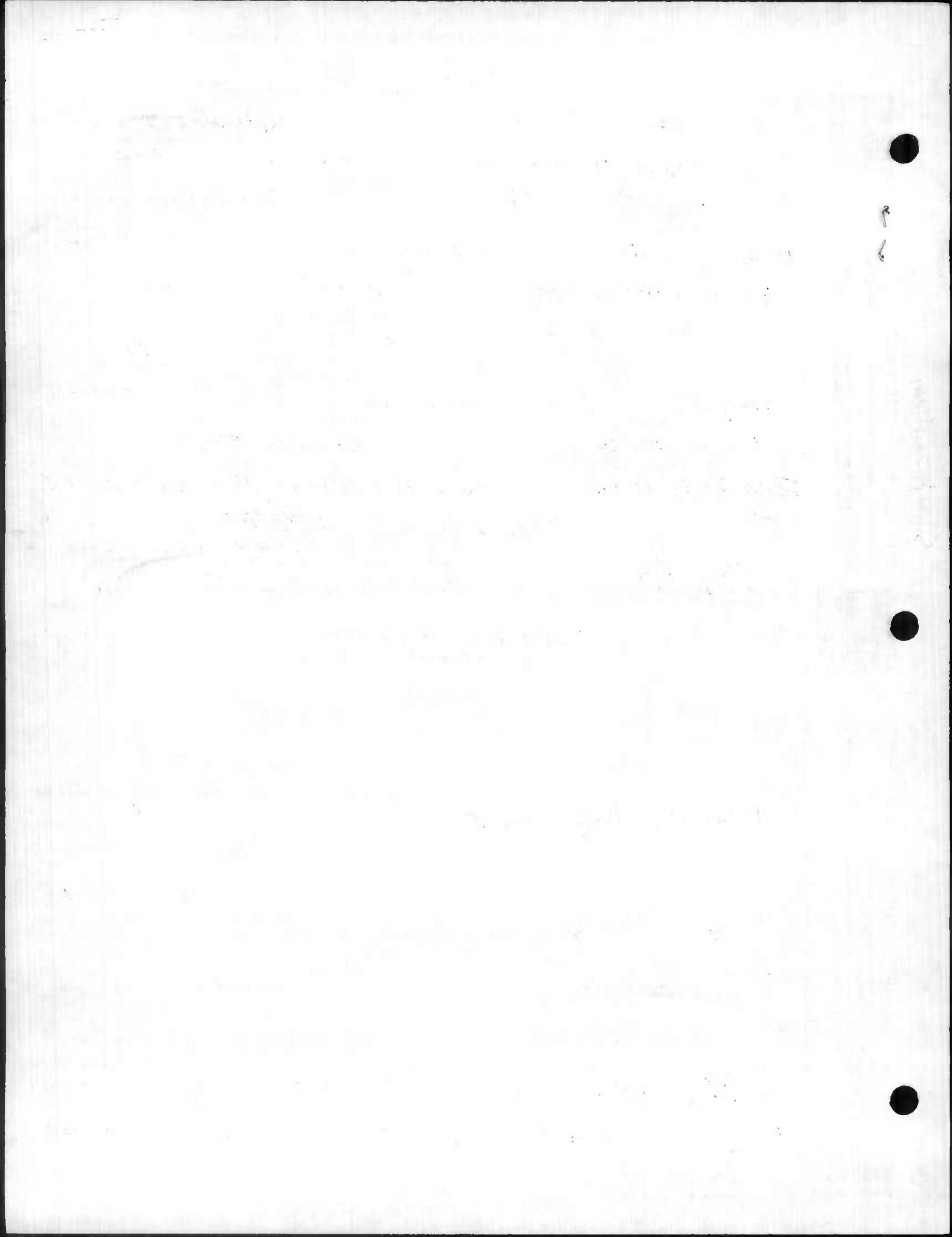
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Smith, William

2

8



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30282

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>Moses Staton, Jr.</b>  |  | 2. Date of Death<br>Month <b>SEPT.</b> Day <b>22,</b> Year <b>2000</b>  |   | 3. Time of Death<br><b>1320 PM</b>   |   |
| 4a. Facility Name (If not institution, give street and number)<br><b>447 NORTH LAKEWOOD AVENUE</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>NA</b>  |
| 5. Social Security Number<br><b>219-38-7211</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>57</b>   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>02-04-43</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  |   |   |  |   |
| Usual Residence of Decedent   |  |   |   |  |   |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>NA</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>447 N. Lakewood Avenue</b>   |  |   | 10f. Zip Code<br><b>Baltimore</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>  |   |  |   |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Senior Pipe Layer</b>   |  | 16b. Kind of Business/Industry<br><b>Baltimore City Water Department</b>  |   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Moses Staton, Sr.</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Roxie Powell</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anne Staton</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3202 Clarence Avenue Baltimore, MD. 21213</b> |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>09-28-2000 Baltimore, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM. C. March FH 1101 E. North Avenue</b>   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypertensive Arteriosclerosis</b><br>Due to (or as a consequence of):<br><b>b. Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   |  |   |   |  | 24a. Was an autopsy performed?<br><b>INSPECTION</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
| 28d. Describe how injury occurred   |  | 28e. Place of injury - (At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>SEPT. 22, 2000</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  | 32. Registrar's Signature<br>   |   |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 must be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30283

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>KURT SCHULTES</b>  |  |   |  | 2. Date of Death<br>Month <b>SEPT.</b> Day <b>21</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>620 PM</b>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>203 LOCKWOOD COURT</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>ANNAPOLIS</b>   |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>                              |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-46-6780</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F   |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 6, 1933</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Anne Arundel</b>   |  | 10c. City, Town or Location<br><b>Annapolis</b>                         |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No <b>X</b>  |  | 10e. Street and Number<br><b>203 Lockwood Court</b>   |  | 10f. Zip Code<br><b>21403</b>  |  | 10g. Citizen of What Country?<br><b>Germany</b>                         |  |
|   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> <b>X</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> <b>X</b> No<br>If Yes, Give Year or Dates:                 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> <b>X</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unk.</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Iron Worker</b> |  | 16b. Kind of Business/Industry<br><b>Steel Industry</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Unk.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Magda Schultes</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Oscar H. Schultes/uncle</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2588 Davidsonville Road Gambrills, MD 21054</b>        |  |   |  |
|   | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> <b>X</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>                          |  | Date<br><b>9/22/00</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |  |
| To Be Completed by Physician/Medical Examiner   | 21. Signature of funeral Service Licensee<br><b>Dawn F. McDonald</b>  |  | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>       |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>ATHEROSCLEROTIC HEART DISEASE</b></p> <p>Due to (or as a consequence of):</p> <p>b. <b>HYPERTENSION</b></p> <p>Due to (or as a consequence of):</p> <p>c.</p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 10%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>UNKNOWN</b></p> <p><b>UNKNOWN</b></p> </div> </div> |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> <b>X</b> No <b>3</b> Probably <b>4</b> Unknown                             |  |   |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> <b>X</b> No  |  |   |  |
|   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |  |   |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending Investigation <b>6</b> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No             |   |  |
|   |   | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |  |   |  |
|   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> <b>X</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><b>KINGSON WOO</b>   |   |  |   | 29c. License number<br><b>D47184</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPT. 22, 2000</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KINGSON WOO 7010 PITCHER HWY, GLEN BURNE, MD 21061</b>   |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br><b>Sparks</b>   |   |  |  |  |   |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

AMEND ITEM: #20C PER F.H. G788 10-2-00 WR.

Reg. No. 00 30284

|  |   |  |  |  |   |  |   |  |  |
|--|---|--|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>GENEVA K. SHAW  |  |  |  | 2. Date of Death<br>Month Day Year<br>SEPT. 20 2000   |  | 3. Time of Death<br>7:48am  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>ROLAND PARK PLACE   |  |  |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |  | 4c. County of Death<br>N/A  |  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>215-48-4140  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F         |  | 7. Age (In yrs. last birthday)<br>96 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>01/16/1904   |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>MICHIGAN  |  | 10a. State<br>MD   |  | 10b. County<br>N/A  |  | 10c. City, Town or Location<br>BALTIMORE  |  |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br>830 WEST 40TH STREET  |  | 10f. Zip Code<br>21211  |  |  |
|  | 10g. Citizen of What Country?<br>USA  |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4YRS                               |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>SECRETARY  |  |  |  | 16b. Kind of Business/Industry<br>SECRETARY   |  |   |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>FREDERICK KRABACH  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ALICE WARD   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>GEORGIA S. HOWARTH(DAUGHTER)  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1963 BAYVIEW DR. BAR HARBOR, MAINE 04609   |  |   |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>DRUID RIDGE CEMETERY  |  | 20c. Location - City or Town, State<br>09/22/ PIKESVILLE, MD.   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>William K. Davis   |  |  |  | 22. Name and Address of Facility<br>HENRY W. JENKINS & SONS CO.<br>4905 YORK RD. BALTO., MD. 21212.   |  |   |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Cerebrovascular accident<br>Due to (or as a consequence of):<br>f. Congestive Heart Failure<br>Due to (or as a consequence of):<br>g. Hypertension<br>Due to (or as a consequence of):<br>h. Diabetes mellitus |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br>MIN.   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| To Be Completed by<br>Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |   |  |   |  |  |
|  | 29b. Signature and title of certifier<br>Marguerite J. Moran M.D.   |  |  |  | 29c. License number<br>D0008093   |  | 29d. Date signed (Month, Day, Year)<br>9-20-2000  |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MARGUERITE MORAN M.D. 200 EAST 33RD ST. BALTO., MD. 21218.  |  |  |  |   |  |   |  |  |
|  | 31. Date filed (Month, Day, Year)<br>SEP 26 2000  |  |  |  | 32. Registrar's Signature<br>Benjamin B. Sparks   |  |   |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30285

|  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>David Wayne Shifflett</b>   |  |  |  | 2. Date of Death<br>Month <b>Sept</b> Day <b>24</b> Year <b>2000</b>   |  | 3. Time of Death<br><b>6:30pm</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>718 Pheasant Dr.</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Forest Hill</b>   |  | 4c. County of Death<br><b>Harford</b>   |  |
| Funeral<br>Director                              | 5. Social Security Number<br><b>213-68-9418</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>43</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 24, 1957</b>   |  |
|  | 9. Usual Residence of Decedent   |  | 10a. State<br><b>Md</b>  |  | 10b. County<br><b>Harford</b>  |  | 10c. City, Town or Location<br><b>Forest Hill</b>   |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |  |  |  | 10e. Street and Number<br><b>718 Pheasant Dr.</b>  |  | 10f. Zip Code<br><b>21050</b>   |  |
|  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                                |  |
| To Be Completed by<br>Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b> |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>self employed</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Sunpaper agent</b>  |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Elvin Shifflett</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucille Williams</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Shifflett wife</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>718 Pheasant Dr. Forest Hill, Md 21050</b> |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Centre U.M.Ch. Ceme</b>   |  | 20c. Location - City or Town, State<br><b>Forest Hill, Md</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Krista L. Wells</b>  |  |  |  | 22. Name and Address of Facility<br><b>EVANS FUNERAL CHAPEL<br/>3 Newport Dr Forest Hill, Md 21050</b>   |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACUTE RENAL FAILURE</b><br>Due to (or as a consequence of):<br><b>b. HEPATORENAL SYNDROME</b><br>Due to (or as a consequence of):<br><b>c. ACUTE LYMPHOBLASTIC LEUKEMIA</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>2 DAYS</b><br><b>1 WEEK</b><br><b>6 MONTHS</b>                                     |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                 |  |
| To Be Completed by<br>Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                               |  |
|  | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |  |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending investigation <b>6</b> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred  |  |  |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  | 29b. Signature and title of Certifier<br><b>Dr. G. S. S. S.</b>   |  |
|  | 29c. License number<br><b>047390</b>   |  |  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>Sept. 25, 2000</b>  |  |
| To Be Completed by<br>Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. BORRULLO 1650 Orleans St Baltimore, Md.</b>   |  |  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  |
|  | 32. Registrar's Signature<br><b>Brenda B. Sparks</b>   |  |  |  |  |  | 33. Date of Death<br><b>SEP 24 2000</b>   |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30286

|  |   |                           |   |  |  |  |  |  |
|--|---|---------------------------|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Eleanor E. Shannon</b>                       |                           |   |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 23, 2000</b>  |  | 3. Time of Death<br><b>1:32 P.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b> |                           |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-20-4376</b>   |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>June 2, 1927</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                      |
|  | Usual Residence of Decedent   |                           |   |  |  |  |  |  |
| 10a. State<br><b>Md.</b>   |   | 10b. County<br><b>N/A</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>1615 Parkman Avenue</b>   |   |                           |   | 10f. Zip Code<br><b>21230</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+) <b>0</b>   |   |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>August Struss</b>  |   |                           |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eleonore Elizabeth Williams</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward S. Shannon ( Husband )</b>   |   |                           |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1615 Parkman Avenue Baltimore, Maryland 21230</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>9/27/00 Baltimore, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Kevin E. Ecker</b>   |   |                           |   | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home, P.A.<br/>237 E. Patapsco Avenue Baltimore, Maryland 21225</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Coronary Vascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |                           |   |  |  |  |  | Approximate Interval Between Onset and Death                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinsons Disease</b>  |   |                           |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |                           |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   |                           |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                           |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |                           |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |   |                           |   | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                           |   | 29b. Signature and title of certifier<br><b>Kevin E. Ecker</b>   |  | 29c. License number<br><b>D38543</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 25, 2000</b>                 |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Kevin H. Schenck 900 Caton Avenue Baltimore, Maryland 21229</b>   |   |                           |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   |                           |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene 00 30287  
Certificate of Death

Reg. No.

|   |   |   |  |  |   |
|---|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Howard E. Simmons</u>                    |   | 2. Date of Death<br>Month <u>September</u> Day <u>23</u> Year <u>2000</u>  |  | 3. Time of Death<br><u>05:00am</u>          |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Mercy Hospital</u> |   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |  | 4c. County of Death<br><u>City</u>          |
| Funeral<br>Director   | 5. Social Security Number<br><u>213-30-5434</u>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>66</u> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.              |
|   | 8. Date of Birth (Month, Day, Year)<br><u>5-3-1934</u>                                  |   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>  |  |   |
| Usual Residence of Decedent   |   |   |  |  |   |
| 10a. State<br><u>MD</u>   |   | 10b. County<br><u>Anne Arundel</u>  |  | 10c. City, Town or Location<br><u>Glen Burnie</u>  |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |
| 10e. Street and Number<br><u>876 North Shore Drive</u>  |   |   | 10f. Zip Code<br><u>21060</u>  |  | 10g. Citizen of What Country?<br><u>USA</u> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>   |   |   |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6th</u> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Sales Representative</u>  |  | 16b. Kind of Business/Industry<br><u>Wisner Electric Co.</u>   |   |
| 17. Father's Name (First, Middle, Last)<br><u>Henry B. Simmons Sr.</u>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Emma Kennel</u>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Emma Di Maio daughter</u>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>6674 Midsummer Night Ct., Sykesville, MD 21784</u> |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Meadowridge</u>  |  | 20c. Location - City or Town, State<br><u>9/26/00 Baltimore, Maryland</u>  |   |
| 21. Signature of Funeral Service Licensee<br><u>► Maria A. Zannino</u>  |   | 22. Name and Address of Facility<br><u>Joseph N. Zannino Jr., Funeral Home</u><br><u>263 South Conkling Street, Baltimore, Maryland 21224</u>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)   |   |   |  |  |   |
| a. <u>Stroke</u><br>Due to (or as a consequence of):  |   |   |  |  |   |
| b. <u>Peripheral Vascular Disease</u><br>Due to (or as a consequence of):   |   |   |  |  |   |
| c.<br>Due to (or as a consequence of):  |   |   |  |  |   |
| d.<br>Due to (or as a consequence of):  |   |   |  |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |   |
| 29b. Signature and title of certifier<br><u>► Karen A. Kozice MD</u>  |   | 29c. License number<br><u>D40744</u>  |  | 29d. Date signed (Month, Day, Year)<br><u>September 23, 2000</u>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>K.A. Kozice, MD Mercy Hospital 301 St Paul Pl, Baltimore, MD 21202</u>   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><u>SEP 26 2000</u>   |   | 32. Registrar's Signature<br><u>► [Signature]</u>   |  |  |   |

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State of Maryland / Department of Health and Mental Hygiene

AMENDED Item #20b per FHG787 9/29/2000 EW

## Certificate of Death

Reg. No.

00 30288

|   |   |                           |   |  |   |  |  |   |
|---|---|---------------------------|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Rebecca Talley</b>   |                           |   |  | 2. Date of Death<br>Month <b>09</b> Day <b>14</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>10:45am</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Multimedical</b>   |                           |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  | 4c. County of Death<br><b>Balto county</b>   |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>230-26-1545</b>   |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>06-17-1923</b>   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |
|   | Usual Residence of Decedent   |                           |   |  |   |  |  |   |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>W/D</b> | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |
|   | 10e. Street and Number<br><b>4589 FREEDOMWAY WEST</b>   |                           |   |  | 10f. Zip Code<br><b>21213</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th grade</b> College (1-4 or 5+)  |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEKEEPING</b>                  |  | 16b. Kind of Business/Industry<br><b>Private Industry</b>   |  |  |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>THEODORE BROWN</b>  |                           |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY WOOD</b>   |  |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dottie Fulkas Niece</b>  |                           |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1365 Pentwood Road Baltimore Md 21239</b>   |  |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Washell Memorial Garden</b>  |  | Date<br><b>9/19/2000</b>  |  | 20c. Location - City or Town, State<br><b>Dundalk, Maryland</b>  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Larry Shuler</b>  |                           | 22. Name and Address of Facility<br><b>5244 PEISTERMAN ROAD BALTIMORE, Maryland 21215</b>   |  |   |  |  |   |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                           |   |  |   |  |  |   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>Congestive Heart Failure</b> months   |                           |   |  |   |  |  |   |
|   | Due to (or as a consequence of):<br><b>Arteriosclerotic Coronary Artery Disease</b> years   |                           |   |  |   |  |  |   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Renal insufficiency</b><br><b>Hypothyroidism</b>   |                           |   |  |   |  |  |   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal insufficiency</b><br><b>Hypothyroidism</b>   |                           |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   |   |                           |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   |   |                           |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                           |   |  |   |  |  |   |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |                           |   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |  |   |
|   | 28a. Date of Injury (Month, Day, Year)  |                           | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   |
|   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                           |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                           |   |  |   |  |  |   |
| State Registrar                               | 29b. Signature and title of certifier<br><b>[Signature]</b>   |                           |   |  | 29c. License number<br><b>D17118</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Sept 18, 2000</b>  |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Schwartz M.D. 10 E. McKeon Ave 21212</b>  |                           |   |  |   |  |  |   |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |                           | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |  |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30289

AMEND#11 PER INFMT. G788 10-6-2000 JAB

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |  |   |
|--|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ronald Lee Trovinger</b>                     |   |  |  | 2. Date of Death<br>Month Day Year<br><b>Sept. 20, 2000</b> |  | 3. Time of Death<br><b>5:45P.M.</b>        |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>71 Lakeshore Drive</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Pasadena</b>     |  | 4c. County of Death<br><b>Anne Arundel</b> |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-36-8119</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                              | 8. Date of Birth (Month, Day, Year)<br><b>May 13, 1940</b>                                     |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Pasadena</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
| 10e. Street and Number<br><b>71 Lakeshore Drive</b>  |   |   |  | 10f. Zip Code<br><b>21122</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1962-64</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>0</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Pile Driver</b>  |   | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Benton L. Trovinger</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edith Baker</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan F. Trovinger Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>71 Lakeshore Drive, Pasadena, Maryland 21122</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b>   |  | 20c. Location - City or Town, State<br><b>9-22-00 Baltimore, Maryland</b>  |   |  |  |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>McCully-Polyniak Funeral Home P.A.<br/>3204 Mountain Road, Pasadena, Maryland 21122</b>   |   |  |  |   |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   |   |  | Approximate Interval Between Onset and Death<br><b>Immediate</b>   |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |   |
|  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |
|  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred                           |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.   |   |   |  |  |   |  |  |   |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>D36203</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>9-21-00</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Ian Shantz 4191 Mountain Rd Pasadena MD 21122</b>   |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   |   |  | 32. Registrar's Signature<br>  |   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30290

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas W. Torpey

2. Date of Death

September 24, 2000 9:30pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

197-01-8705

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 4, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

New Jersey

10b. County

Hudson

10c. City, Town or Location

Jersey City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

15 Glenwood Avenue

10f. Zip Code

07306

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

n/a

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Ironworker

16b. Kind of Business/Industry

Iron

17. Father's Name (First, Middle, Last)

Maurice

Torpey

18. Mother's Name (First, Middle, Maiden Summa)

Mary

Mc Cann

19a. Informant's Name/Relationship (Type, Print)

Margaret May Doherty/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

328 Stevens Avenue, Jersey City, NJ

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Cross Cemetery

Date

9/28/00 North Arlington, NJ

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lemmon Funeral Home

10 W. Padonia road, Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

9/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

SEPTEMBER 24, 2000 9:30 p.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

THOMAS TORPEY

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 30291

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |  |  |
|--|--|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Lorraine T. Thiem  |  |   |  | 2. Date of Death<br>Month Day Year<br>September 22, 2000  |  |  |  | 3. Time of Death<br>4:51 p.m.  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Gilchrist Center   |  |   |  | 4b. City, Town, or Location of Death<br>Towson  |  |  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-22-9593   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>Yrs. 79   |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  |
|  | 8. Date of Birth (Month, Day, Year)<br>June 1, 1921  |  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland  |  | 10b. County<br>Baltimore   |  | 10c. City, Town or Location<br>Towson  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>1118 Greenacre Road   |  | 10f. Zip Code<br>21286  |  | 10g. Citizen of What Country?<br>U.S.A.  |  | 10h. Decedent's Usual Residence (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4                             |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Nursery School Teacher                         |  |
| To Be Completed by Physician/Medical Examiner                                | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Nursery School Teacher   |  | 16b. Kind of Business/Industry<br>Education   |  | 17. Father's Name (First, Middle, Last)<br>Unknown Thomas   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Edward F. Thiem / Husband  |  |
|  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1118 Greenacre Road Towson, Maryland 21286  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial Gds. 9/27/2000  |  | 20c. Location - City or Town, State<br>Timonium, Maryland  |  | 21. Signature of Funeral Service Licensed<br>[Signature]   |  |
| Physician<br>/Medical<br>Examiner  | 22. Name and Address of Facility<br>1050 York Road<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. liver metastases<br>Due to (or as a consequence of):<br>b. pancreatic CA<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>3 mos<br>1 year   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) hospice |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Medical Examiner 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>[Signature]   |  |
|  | 29c. License number<br>D39899  |  | 29d. Date signed (Month, Day, Year)<br>9/24/00  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Rodney W. Williams GARC, BALTIMORE  |  | 31. Date filed (Month, Day, Year)<br>SEP 26 2000   |  | 32. Registrar's Signature<br>[Signature]   |  |

ORIGINAL



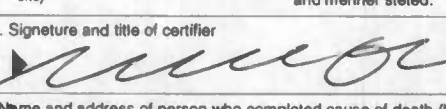
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30292

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |   |  |  |
|--|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>PHILIP CROSBY UPTON</b>                      |   |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 24, 2000</b> |   | 3. Time of Death<br><b>4:55 AM</b>                           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>GENESIS ELDER CARE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>SEVERNA PARK</b>     |   | 4c. County of Death<br><b>ANNE ARUNDEL</b>                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-22-7967</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                |   | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 21, 1924</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                 |   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>ANNE ARUNDEL</b>                              |   | 10c. City, Town or Location<br><b>GLEN BURNIE</b>            |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>212 4TH AVENUE, S.W.</b>   |  | 10f. Zip Code<br><b>21061</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FARM MACHINERY SALESMAN</b>   |  | 16b. Kind of Business/Industry<br><b>FARMING</b>   |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>EDWARD L. UPTON</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>IDA WATTS</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PHIL UPTON (SON)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>510 BAYLOR ROAD, GLEN BURNIE, MARYLAND 21061</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL PARK</b>  |  | 20c. Location - City or Town, State<br><b>ELKRIDGE, MD.</b>  |   | 20d. Date<br><b>9/26/2000</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>  |  |  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>pneumonia, recurrent</b><br>Due to (or as a consequence of):<br>b. <b>dysphagia</b><br>Due to (or as a consequence of):<br>c. <b>Parkinsons Disease</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>less than one day</b><br><b>months</b><br><b>years</b> |   |   |  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive heart failure,<br/>colon cancer, peripheral<br/>vascular disease</b>   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D41955</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>9-25-00</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Rebecca Elton MD 479 Jumpers Hole Rd #304 Severna Park MD 21146</b>   |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>  |   | 32. Registrar's Signature<br>   |  |  |   |   |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30293

AMEND#6 PER F.H. G788 10-4-2000 JAB

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Joseph G. Voelker, Jr.

2. Date of Death

September 23, 2000

3. Time of Death

10:57 PM

4a. Facility Name (If not institution, give street and number)

Singi Hospital of Baltimore

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

218-28-7496

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

9-13-1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Anne Arundel

10c. City, Town or Location

Pasadena

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

103 Southview Lane

10f. Zip Code

21122

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1948-

If Yes, Give Year or Dates: 1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Musician

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Joseph G. Voelker, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Margaret M. Wilkins

19a. Informant's Name/Relationship (Type, Print)

Julia D. Voelker (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Southview Lane, Pasadena MD. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

9-27-00

20c. Location - City or Town, State

Balto., MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home P.A.

3204 Mountain Rd. Pasadena, MD. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anoxic Brain Injury  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Transient Ischemic Attacks, End-stage Renal

Failure, Hypercholesterolemia, COPD, Asbestosis, PVD,

Polymyalgia Rheumatica, HTN, Seizures, Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28i. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. J. L. DO

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

September 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYAM KASHI, to Singi Hospital of BALTIMORE

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JOSEPH VOELKER





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30294

Amended Item#19b per FHG788 10/25/2000 EW

## Certificate of Death

Reg. No.

|   |   |  |  |   |   |   |  |  |
|---|---|--|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Anne VanLeeuwen</b>                                |  |  |   | 2. Date of Death<br>Month Day Year<br><b>September 22, 2000</b> |   | 3. Time of Death<br><b>2:08 PM</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Chapel Hill Nursing Home</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>Randallstown</b>     |   | 4c. County of Death<br><b>Baltimore</b>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>202-09-5633</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.                |   | 8. Date of Birth (Month, Day, Year)<br><b>May 24, 1917</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                   |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>                                 |   | 10c. City, Town or Location<br><b>Randallstown</b>         |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cashier</b>  |  | 16b. Kind of Business/Industry<br><b>Acme</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Joseph Danko</b>  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susan Fonslick</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. John Stupi</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9201 Allenswood Road, Randallstown, Md 21133</b>  |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Woodlawn, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Alan Seitz</b>  |   | 22. Name and Address of Facility<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road, Randallstown, MD 21133</b>   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>CHF, Hypotensive</b><br>Due to (or as a consequence of)<br>b. <b>CHF, Recent M.I.</b><br>Due to (or as a consequence of)<br>c. <b>Dementia, Osteoporosis</b><br>Due to (or as a consequence of)<br>d. <b>HTN, Aseps</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)<br><b>9/25/00</b>  |  |  |
| 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>S. Sinding, MD</b>  |   | 29c. License number<br><b>D30119</b>  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>9/25/00</b>   |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Shahida Siddiqi, 6212 Sykesville Rd, Sykesville, Md 21157</b>   |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30295

|   |   |  |   |   |  |
|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD WASHINGTON</b>   |  | 2. Date of Death<br>Month <b>September</b> Day <b>23</b> Year <b>2000</b>   |   | 3. Time of Death<br><b>01:41 AM</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE Johns Hopkins Hospital</b>   |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |   | 4c. County of Death  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-28-0496</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><b>6-19-1933</b> | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
|   | Usual Residence of Decedent   |  |   |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   | 10b. County  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>2818 PRESSTMAN STREET</b>  |  | 10f. Zip Code<br><b>21216</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>   |   | 16b. Kind of Business/Industry<br><b>LAUNDRY SERVICE</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>RICHARD WASHINGTON</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>OLA WASHINGTON</b>  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>YVETTE CURTIS (SISTER)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1030 LAKEMONT RD. BALTIMORE MD 21228</b>  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. LUKE CEM.</b>  |   | 20c. Location - City or Town, State<br><b>SEPT. 26, 00 REISTERSTOWN MD</b>   |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>ESTEP BROS FUNERAL SERVICE</b><br><b>1300 EUTAW PLACE BALTIMORE MD 21217</b>   |   |  |
|   | 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>sepsis</b><br><br>Due to (or as a consequence of):<br><b>aspiration pneumonia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>pulmonary hypertension</b><br><b>congestive heart failure</b> |  | Approximate Interval Between Onset and Death<br><b>10 hours</b><br><b>12 hours</b>  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br><b>SEP 20 2000</b>  |   |  |
| To Be Completed by Physician/Medical Examiner | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><br><b>SHANNON J. WINAKUR MD PHYSICIAN</b>   |   |  |
|   | 29c. License number<br><b>RES-000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 23, 2000</b>  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHANNON J. WINAKUR, MD; JOHNS HOPKINS HOSPITAL; 600 NORTH WOLFE STREET; BALTIMORE, MARYLAND</b>  |  |   |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |  | 32. Registrar's Signature<br>   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



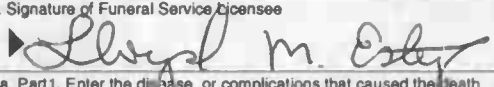
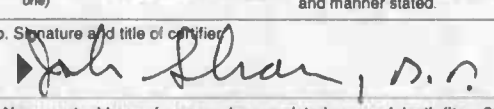
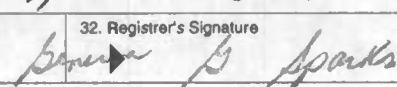
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30296

## Certificate of Death

Reg. No.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>SUSIE WILLIAMS!</b>  |   | 2. Date of Death<br>Month <b>09</b> Day <b>21</b> Year <b>2000</b>   |   | 3. Time of Death<br><b>3:40 pm</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Bon Secour Hospital</b>  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |   | 4c. County of Death<br><b>City</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>238-38-8874</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>8/22/27</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Enfield, N.C.</b>   |   |   |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|  | 10a. State<br><b>Md.</b>  | 10b. County   | 10e. Street and Number<br><b>1010 W. Baltimore St.</b>   |   | 10f. Zip Code<br><b>21223</b>   |
|  | 10g. Citizen of What Country?<br><b>USA</b>   |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Pastor</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Church</b>   |   | 16b. Kind of Business/Industry  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Sam Whitaker</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clare Whitaker</b>   |   |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Adele Gray</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>617 Greystone Ave, Jacksonville, N.C. 28540</b>                            |   |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>9/28/00 Baltimore, Md.</b>  |
|  | 21. Signature of Funeral Service licensee<br>   |   | 22. Name and Address of Facility<br><b>Estep Brothers Funeral Ser, P.A.<br/>1300 Eutaw Place, Baltimore, Md. 21217</b>   |   |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONCUSSION WITH FAILURE 10 DAY!</b><br>Due to (or as a consequence of):<br><b>b. ANTIHYPERTENSIVE CANNULOSIS 15 YRS.</b><br>Due to (or as a consequence of):<br><b>DISSECTION</b><br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>                       |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how Injury occurred   |  |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |   |   |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>022838</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/22/00</b> |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN SPARKS, M.D. 578 CAMP HANCOCK RD. LINTHicum, MD 21040</b>  |   |   |  |   |   |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br>   |   |   |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30297

|   |  |   |   |  |   |  |   |  |   |  |
|---|--|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Lynette White</b>                                       |   |   |  | 2. Date of Death<br>Month <b>Sept.</b> Day <b>23</b> Year <b>2000</b>   |  |   |  | 3. Time of Death<br><b>6:14am</b>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Lorien Frankford Nursing Home</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  |   |  | 4c. County of Death<br><b>NA</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-72-6409</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>01-01-55</b>                                      |  | 9. Birthplace (State or Foreign Country)<br><b>DC</b>                   |  |
|   | Usual Residence of Decedent  |   |   |  |   |  |   |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>                                |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>2920 E. Baltimore Street</b>   |  |   |   | 10f. Zip Code<br><b>21224</b>  |   |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>black</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>High Sch. Grad</b> College (1-4 or 5+) <b>NA</b>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b> |   |  |   | 16b. Kind of Business/Industry<br><b>Company</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Melvin White</b>  |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Susie Carroll</b>   |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Eric White</b>   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2920 E. Baltimore Street Baltimore, MD. 21224</b> |  |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Voshell Mem. Gardens</b>   |  |   | Date<br><b>09-28-2000</b>  |   | 20c. Location - City or Town, State<br><b>Dundalk, MD</b>                                      |   |  |
| 21. Signature of Funeral Service Licensee<br><b>► Gladys Wane</b>   |  |   |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202<br/>WM. C. March FH 1101 E. North Avenue</b>   |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>End stage metastatic Carcinoma 1 YR.</b>  |  |   |   |  |   |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |  |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |   |  |   |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                                       |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |  |   |  |   |  |
| 29b. Signature and title of certifier<br><b>► Ramesh Sabapathi</b>  |  |   |   |  | 29c. License number<br><b>D30641</b>  |  |   | 29d. Date signed (Month, Day, Year)<br><b>9-26-00</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ramesh Sabapathi 3400 Erdman Ave Baltimore MD 21218</b>  |  |   |   |  |   |  |   |  |   |  |
| State Registrar   |  | 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b> |   | 32. Registrar's Signature<br><b>Benjamin Sparks</b>  |   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30298

Amended Item#23a,27 per MEOG788 10/12/2000 EW Certificate of Death

Reg. No.

|   |   |  |  |  |   |  |                                |  |   |  |
|---|---|--|--|--|---|--|--------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>TROY C. WILLIS</b>                           |  |  |  | 2. Date of Death<br>Month Day Year<br><b>September 19, 2000</b> |  |                                |  | 3. Time of Death<br><b>2118 pm</b>              |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>1916 Ruxton Avenue</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>        |  |                                |  | 4c. County of Death<br><b>N/A</b>               |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-84-1595</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>38</b> Yrs.                |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.                  |  |
|   | 8. Date of Birth<br>(Month, Day, Year)<br><b>6-16-62</b>                                    |  | 9. Birthplace (State or Foreign Country)<br><b>BALTO. MD</b>               |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>      |  | 10c. City, Town or Location<br><b>BALTIMORE</b> |  |
| Usual Residence of Decedent   |   |  |  |  |   |  |                                |  |   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |  |   |  |                                |  |   |  |
| 10e. Street and Number<br><b>1916 RUXTON AVE</b>  |   |  |  |  |   |  |                                |  |   |  |
| 10f. Zip Code<br><b>21216</b>   |   |  |  |  |   |  |                                |  |   |  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |  |  |   |  |                                |  |   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  |  |  |   |  |                                |  |   |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   |  |  |  |   |  |                                |  |   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |  |  |  |   |  |                                |  |   |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |   |  |  |  |   |  |                                |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>   |   |  |  |  |   |  |                                |  |   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>  |   |  |  |  |   |  |                                |  |   |  |
| 16b. Kind of Business/Industry<br><b>TRANSPORTATION</b>   |   |  |  |  |   |  |                                |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>TIMOTHY HYMAN</b>   |   |  |  |  |   |  |                                |  |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SUSIE WILLIS</b>  |   |  |  |  |   |  |                                |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SUSIE WILLIS, MOTHER</b>   |   |  |  |  |   |  |                                |  |   |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1916 RUXTON AVE, BALTO. MD 21216</b>  |   |  |  |  |   |  |                                |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  |  |  |   |  |                                |  |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WESTERN STAR</b>   |   |  |  |  |   |  |                                |  |   |  |
| 20c. Location - City or Town, State<br><b>09-25-00 BALTO. MD</b>  |   |  |  |  |   |  |                                |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |  |  |  |   |  |                                |  |   |  |
| 22. Name and Address of Facility<br><b>HOWELL FUNERAL HOME</b><br><b>4600 LIBERTY HGHTS AVE, BALTO. MD 21207</b>  |   |  |  |  |   |  |                                |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ACQUIRED IMMUNE DEFICIENCY SYNDROME</b><br>Due to (or as a consequence of):<br><b>b. HUMAN IMMUNODEFICIENCY VIRUS INFECTION</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |   |  |                                |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |  |   |  |                                |  |   |  |
| 24a. Was an autopsy performed?<br><b>INSPECTION</b><br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |  |   |  |                                |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |   |  |                                |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |  |  |   |  |                                |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>   |   |  |  |  |   |  |                                |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 8 <input type="checkbox"/> Could not be determined   |   |  |  |  |   |  |                                |  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   |  |  |  |   |  |                                |  |   |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |  |  |   |  |                                |  |   |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |   |  |                                |  |   |  |
| 28d. Describe how injury occurred   |   |  |  |  |   |  |                                |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  |  |   |  |                                |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |  |                                |  |   |  |
| 29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |  |  |   |  |                                |  |   |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |  |  |  |   |  |                                |  |   |  |
| 29c. License number<br><b>O.C.M.E.</b>  |   |  |  |  |   |  |                                |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>September 20, 2000</b>  |   |  |  |  |   |  |                                |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY C. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |  |   |  |                                |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   |  |  |  |   |  |                                |  |   |  |
| 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |   |  |                                |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30299

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Gary S. Yealdhall</b>                            |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 19, 2000</b> |  | 3. Time of Death<br><b>1711 PM</b>      |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2405 GREEN SUMMIT ROAD</b> |   | 4b. City, Town, or Location of Death<br><b>PIKESVILLE</b>       |  | 4c. County of Death<br><b>BALTIMORE</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>218 80 7281</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.                | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.          |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 26, 1958</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>     |  |   |
| Usual Residence of Decedent   |   |   |   |  |   |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Anne Arundel</b>  |   | 10c. City, Town or Location<br><b>Severna Park</b>   |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |  |   |
| 10e. Street and Number<br><b>281 Shakespear Drive</b>   |   | 10f. Zip Code<br><b>21146</b>   |   | 10g. Citizen of What Country?<br><b>U.S.</b>   |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Commercial Artist</b>   |   | 16b. Kind of Business/Industry<br><b>Printing &amp; Advertising</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Yealdhall</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Phyllis Priestley</b>   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Teresa Shannon / Wife</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>281 Shakespear Drive Severna Park, Maryland 21146</b>   |   |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |   | 20c. Location - City or Town, State<br><b>9/25/00 Towson, Maryland</b>   |   |
| 21. Signature of Funeral Service Licensee<br><i>Dan Znamenski</i>   |   | 22. Name and Address of Facility<br><b>Gonce Funeral Home P.A.<br/>4001 Ritchie Highway Baltimore, Md. 21225</b>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CARBON MONOXIDE INTOXICATION</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |
| 24a. Was an autopsy performed?<br><b>INSPECTION</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |   |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>9/19/00</b>  |   | 28b. Time of Injury<br><b>1700 PM</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred<br><b>SUBJECT PLACED HOSE ON TAIL PIPE OF CAR AND DIRECTED IT INTO CAR INTOXICATING HIMSELF WITH CARBON MONOXIDE</b>  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>2405 GREEN SUMMIT RD, PIKESVILLE, MD</b>  |   |
| 28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>IN CAR IN PARKING LOT</b>  |   |   |   |  |   |
| 29e. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   |  |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i> M.D.  |   | 29c. License number<br><b>OCME</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 20, 2000</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 26 2000</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



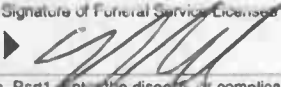
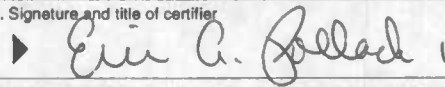
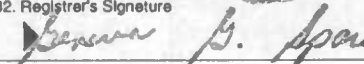
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30300

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>PHILIP ARNOLD</b>                           |   |  |   | 2. Date of Death<br>Month <b>SEPT</b> Day <b>12</b> Year <b>2000</b> |   | 3. Time of Death<br><b>12:55 AM</b>                        |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>              |   | 4c. County of Death<br><b>MONTGOMERY</b>                   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-42-4159</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>FEB 23, 1909</b> |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>NEW JERSEY</b>                              |   | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>MONTGOMERY</b>                                     |   | 10c. City, Town or Location<br><b>POTOMAC</b>              |  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>11215 SEVEN LOCKS ROAD</b>   |  | 10f. Zip Code<br><b>20854</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (13 or 5+) <input checked="" type="checkbox"/>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PATENT ATTORNEY</b>                 |  | 16b. Kind of Business/Industry<br><b>US GOVERNMENT</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>MAX ARONOWSKY</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE HONDVAGON</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HOWARD M. ARNOLD / SON</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9825 CONESTOGA WAY, POTOMAC, MARYLAND 20854</b> |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING DAVID MEMORIAL GDNS</b>   |  | 20c. Location - City or Town, State<br><b>FALLS CHURCH, VIRGINIA</b>   |  |
| 21. Signature of Funeral Service Licensed<br>   |  | 22. Name and Address of Facility<br><b>EDWARD SAGEL FUNERAL DIRECTION, INC.<br/>1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>                  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (First disease or condition resulting in death)<br><b>a. Aspiration pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Small bowel obstruction</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  |
| 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>                        |  | 29c. License number<br><b>52000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 12, 2000</b>  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ERIC A. POLLACK, MD 9711 Medical Center Drive Suite 308 Rockville, Maryland 20850</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>   |  | 32. Registrar's Signature<br>                                    |  | State Registrar   |  | Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020   |  | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. |  |

ORIGINAL

008 2 00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 30301**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Constance Greenman Andre

2. Date of Death  
Month Day Year  
Sept. 12, 20003. Time of Death  
11:55amFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

111-30-2430

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 21, 1938

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5608 Granby Road

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

President

16b. Kind of Business/Industry

Volunteer Foreign  
Diplomatic Community

17. Father's Name (First, Middle, Last)

William Burt Greenman

18. Mother's Name (First, Middle, Maiden Surname)

Hope Graham

19a. Informant's Name/Relationship (Type, Print)

Donn R. Andre (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5608 Granby Road, Derwood, MD 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

9/13/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Robert J. DeVol

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Metastatic Breast Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Kaplan MD

29c. License number

D 35635

29d. Date signed (Month, Day, Year)

SEPTEMBER 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan 1811 Prince Philip Dr Olney, MD 20832

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

Bernice B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30302  
Certificate of Death

Reg. No.

|   |  |   |   |   |   |   |  |   |   |  |
|---|--|---|---|---|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ruthmary Alderson</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>Sept. 8, 2000</b>  |   |  |   | 3. Time of Death<br><b>0035</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |   |  |   | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>221-30-8211</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |   | If Under 1 Year<br>Months Days                                   |   | If Under 24 Hrs.<br>Hours Min.  |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 18, 1918</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Canada</b>   |   | 10a. State<br><b>Florida</b>  |   | 10b. County<br><b>Pinnellas</b>                                  |   | 10c. City, Town or Location<br><b>Clearwater</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>1748 Brentwood Drive</b>   |   |   |   | 10f. Zip Code<br><b>33756-4607</b>                               |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:           |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                 |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                               |   | 16b. Kind of Business/Industry<br><b>Own Home</b>   |   |  |   |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harry T. Mason</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. Stone</b>   |   |  |   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas Alderson, IV/Husband</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1748 Brentwood Drive, Clearwater, Florida 33756-4607</b>                                  |   |  |   |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |   | Date<br><b>Sept 11 2000</b>   |   | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b> |   |   |  |
|   | 21. Signature of Funeral Service Licensee<br> <b>MO0803</b>  |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b> |   |   |   |  |   |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hemophysis</b><br>Dua to (or as a consequence of):<br><b>b. Metastatic Thyroid Carcinoma</b><br>Dua to (or as a consequence of):<br><b>c.</b><br>Dua to (or as a consequence of):<br><b>d.</b> |   |   |   | Approximate Interval Between Onset and Death<br><b>1 Hour</b><br><b>2 Years</b>   |   |  |   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |   |  |   |   |  |
|   |  |   |   |   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |   |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                         |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred   |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician <b>2</b> Medical Examiner  |  | 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br><b>14045</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 9, 2000</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David Gross, M.D. 2440 M Street, N.W., #810, Washington, D.C. 20037-1404</b>   |  |   |   | 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b> |   |   |  | 32. Registrar's Signature<br> |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30303

Amend #19b, 9/15/2000, per Inform., JW, Mont. **Certificate of Death**

Reg. No.

|  |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
|--|--|---------------------------------------|---|--|--|---|--|--|--------------------------------|---|--|----|--------------------------|---------|----------------------------------|--|----------------------------------|----|----------------|---------|----------------------------------|--|--|----|--|--|----------------------------------|--|--|----|--|--|
| <b>Physician<br/>/Medical<br/>Examiner</b>   | 1. Decedent's Name (First, Middle, Last)<br><b>Hilde Elfriede Adams</b>  |                                       |   |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>10</b> Year <b>2000</b>                   |  | 3. Time of Death<br><b>10:50am</b>   |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Shady Grove Adventist Nursing Center</b>  |                                       |   |  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>                                    |  | 4c. County of Death<br><b>Montgomery</b>   |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| <b>Funeral<br/>Director</b>  | 5. Social Security Number<br><b>162-28-6472</b>  |                                       | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |   | If Under 1 Year<br>Months Days                                     |  | If Under 24 Hrs.<br>Hours Min. |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
|  | 6. Date of Birth (Month, Day, Year)<br><b>July 7, 1922</b>   |                                       | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>  |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| Usual Residence of Decedent  |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>      |   | 10c. City, Town or Location<br><b>Gaithersburg</b> |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 10e. Street and Number<br><b>24 Brookes Avenue</b>   |  |                                       |   |  | 10f. Zip Code<br><b>20877</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>              |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |                                       |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembly Line Worker</b>   |   |  | 16b. Kind of Business/Industry<br><b>Truck Assembly</b>  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Karl Nixdorf</b>   |  |                                       |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elfriede Knoblich</b>  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Shirley Webber (Daughter)</b>   |  |                                       |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>24 Brookes Avenue, Gaithersburg, MD 20877</b>  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>9/11/00</b>   |   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b> |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                                       |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home<br/>10 East Deer Park Drive<br/>Gaithersburg, MD 20877</b>   |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| <table border="0" style="width:100%;"> <tr> <td style="width:30%; vertical-align: top;"> <b>Immediate Cause (Final disease or condition resulting in death)</b><br/><br/> <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b> </td> <td style="width:60%; vertical-align: top;"> <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">Congestive Heart Failure</td> <td style="width:20%; text-align: center;">1 Month</td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td>Cardiomyopathy</td> <td style="text-align: center;">1 Month</td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td></td> </tr> </table> </td> </tr> </table> |  |                                       |   |  |  |   |  |  |                                | <b>Immediate Cause (Final disease or condition resulting in death)</b><br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b> | <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">Congestive Heart Failure</td> <td style="width:20%; text-align: center;">1 Month</td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td>Cardiomyopathy</td> <td style="text-align: center;">1 Month</td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td></td> </tr> </table> | a. | Congestive Heart Failure | 1 Month | Due to (or as a consequence of): |  |                                  | b. | Cardiomyopathy | 1 Month | Due to (or as a consequence of): |  |  | c. |  |  | Due to (or as a consequence of): |  |  | d. |  |  |
| <b>Immediate Cause (Final disease or condition resulting in death)</b><br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>  | <table border="0"> <tr> <td style="width:5%; text-align: center;">a.</td> <td style="width:75%;">Congestive Heart Failure</td> <td style="width:20%; text-align: center;">1 Month</td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">b.</td> <td>Cardiomyopathy</td> <td style="text-align: center;">1 Month</td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">c.</td> <td></td> <td></td> </tr> <tr> <td colspan="3" style="text-align: center;">Due to (or as a consequence of):</td> </tr> <tr> <td style="text-align: center;">d.</td> <td></td> <td></td> </tr> </table> | a.                                    | Congestive Heart Failure  | 1 Month  | Due to (or as a consequence of):   |   |  | b.   | Cardiomyopathy                 | 1 Month   | Due to (or as a consequence of):   |    |                          | c.      |                                  |  | Due to (or as a consequence of): |    |                | d.      |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| a.   | Congestive Heart Failure   | 1 Month                               |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| Due to (or as a consequence of):   |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| b.   | Cardiomyopathy   | 1 Month                               |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| Due to (or as a consequence of):   |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| c.   |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| Due to (or as a consequence of):   |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| d.   |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure</b>   |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                       |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br><b>M</b>                    |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                       |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 29b. Signature and title of certifier<br> <b>MD</b>   |  |                                       |   |  | 29c. License number<br><b>D28656</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>September 11, 2000</b>   |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ravi Passi, MD 8609 Second Avenue #404B, Silver Spring, MD 20910</b>  |  |                                       |   |  |  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |  |                                       |   |  | 32. Registrar's Signature<br>  |   |  |  |                                |   |  |    |                          |         |                                  |  |                                  |    |                |         |                                  |  |  |    |  |  |                                  |  |  |    |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician /Medical Examiner

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30304

Amend #23a, 9/13/2000, per MD, JW, Mont. Co. *Certificate of Death*

Reg. No.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Rose Abrams</b>   |   | 2. Date of Death<br>Month Day Year<br><b>Sept. 7, 2000</b>  |  | 3. Time of Death<br><b>6:15P.</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care</b>  |   | 4b. City, Town, or Location of Death<br><b>Potomac</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>161-01-4522</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 2, 1918</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   | 10c. City, Town or Location   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>  | <b>Montgomery Village</b>   |  |  |
|  | 10e. Street and Number<br><b>9801 Feathertree Terrace, #102</b>  |   | 10f. Zip Code<br><b>20886</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>  |   | 16b. Kind of Business/Industry<br><b>Education</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Benjamin Wexler</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida Neren</b>   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lois Singer (daughter)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b>   |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Lebanon Cemetery</b>   |   | Date<br><b>9/10/2000</b>   | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerosis</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>year</b>   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |  |  |
|  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>020516</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>September 8, 2000</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Joel R. Schulman 9410 Old Georgetown Rd. Bethesda, Maryland 20814</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |  | 32. Registrar's Signature<br>   |   |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30305

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Erma E. Aarons

2. Date of Death

Month Day Year  
September 7, 2000

3. Time of Death

8:24 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

221-32-5639

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr. 21, 1916

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14519 Cutstone Way

10f. Zip Code

20905

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Bennett Meyers

18. Mother's Name (First, Middle, Maiden Summa)

Ida Harris

19a. Informant's Name/Relationship (Type, Print)

Ralph Aarons/ husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14519 Cutstone Way, Silver Spring, MD 20905

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

National Crematory

Date

Sep. 9, 2000

20c. Location - City or Town, State

Falls Church, VA

21. Signature of Funeral Service Licensee

D. K.

22. Name and Address of Facility

Danzansky-Goldberg Memorial Chapels, Inc.  
1170 Rockville Pike, Rockville, MD 20852

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC RENAL FAILURE  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HYPERTENSION  
Due to (or as a consequence of):

YEARS

c. BRONCHOPNEUMONIA, CHRONIC  
Due to (or as a consequence of):

30 YEARS

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

SEVERE MITRAL REGURITATION

HYPERTENSIVE HEART DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. K.

29c. License number

D25947

29d. Date signed (Month, Day, Year)

SEPTEMBER 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILSON JACKSON, MD 3416 OLANDWOOD COURT, SUITE 200, OLNEY, MD 20832

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30306

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Susie K. Burn

2. Date of Death

Month Day Year  
September 9, 2000

3. Time of Death

5:55 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

11736 Gainsborough Road

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

577-07-8115

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 3, 1910

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11736 Gainsborough Road

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Bank

17. Father's Name (First, Middle, Last)

Michael Joseph Kirby

18. Mother's Name (First, Middle, Maiden Surname)

Mary Stalecker

19e. Informant's Name/Relationship (Type, Print)

Lester T. Burn, Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3 Chalkstone Court, Silver Spring, MD 20904

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

September

20c. Location - City or Town, State

14, 2000 Rockville, Maryland

21. Signature of Funeral Serv

M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 West Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Lymphoma

Due to (or as a consequence of):

Months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Anemia

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Christy Lynn M.D.

29c. License number

D31839

29d. Date signed (Month, Day, Year)

September 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christopher C. Dunford, M.D. 615 West Montgomery Avenue, Rockville, Maryland 20850

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30307

|  |  |  |   |                                      |  |   |   |  |   |  |  |
|--|--|--|---|--------------------------------------|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Ella Mae Bryan</b>  |  |   |                                      | 2. Date of Death<br>Month Day Year<br><b>September 2, 2000</b>   |   |   |  | 3. Time of Death<br><b>7:45 P.M.</b>                  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3106 Farnborough Court</b>  |  |   |                                      | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |   |   |  | 4c. County of Death<br><b>Montgomery</b>              |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-40-9527</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                      | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.   |   | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.                        |  |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>October 22, 1904</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>   |                                      | Usual Residence of Decedent  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>                      |  |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                      | 10e. Street and Number<br><b>3106 Farnborough Court</b>  |   | 10f. Zip Code<br><b>20906</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>   |                                      | 16b. Kind of Business/Industry<br><b>U.S. Government</b>   |   |   |  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Leander Cooley</b>   |  |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella Mae Donn</b>  |   |   |  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Doris M. Fox/ Neice</b>   |  |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13007 Matey Road Silver Spring, MD 20906</b>   |   |   |  |   |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Geo. Wash. University Medical Center</b>   |                                      | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>   |   |   |  |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Columbia Mortuary Services, Inc.<br/>P.O. Box 58007 Washington, D.C. 20037</b>   |                                      |  |   |   |  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Recurrent Gastrointestinal bleeding</b><br>Due to (or as a consequence of):<br><b>c. Severe Diverticulosis</b><br>Due to (or as a consequence of):<br><b>d. Recurrent Bladder infections</b> |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Recurrent Gastrointestinal bleeding</b><br><b>Severe Diverticulosis</b><br><b>Recurrent Bladder infections</b>  |  |   |                                      |  |   |   |  |   |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                      | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)<br><b>September 2, 2000</b>   |  | 28b. Time of Injury<br><b>M</b>                       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br> |   | 29c. License number<br><b>P43202</b> |  | 29d. Date signed (Month, Day, Year)<br><b>September 3, 2000</b>   |   |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>C. Ozanne-Blankford MD</b>  |  | 31. Data filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |   |                                      |  | 32. Registrar's Signature<br> |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

00 30308

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JULIA MAY BREITMAN</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>September 12, 2000</b>  |  | 3. Time of Death<br><b>7:48 A.M.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>10026 Battleridge Place</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Montgomery Village</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>431-46-4975</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 27, 1928</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Alabama</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Montgomery Village</b>   |  |
| To Be Completed by Funeral Director                                       | 10e. Street and Number<br><b>10026 Battleridge Place</b>  |  | 10f. Zip Code<br><b>20886</b>   |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner                             | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (14 or 5+) <b>College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrator</b>                     |  | 16b. Kind of Business/Industry<br><b>U. S. Government</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>William Kohn</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Golden</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Leonard W. Breitman - Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10026 Battleridge Place, Montgomery Village, Md. 20886</b>   |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Judean Memorial Gardens</b>  |  | 20c. Location - City or Town, State<br><b>Olney, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Donald S. Stottmeyer</b>   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>BRAIN FAILURE</b><br>Due to (or as a consequence of):<br><b>NEURONS TO BRAIN FROM CUVG</b><br>Due to (or as a consequence of):<br><b>LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>3 mos</b><br><b>6 mos</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                 |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day Year)<br><b>9/12/00</b>   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| State Registrar   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Stanley A. Schwartz MD</b>   |  |
|   | 29c. License number<br><b>D0017368</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/12/00</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Stanley Schwartz 2730 University Blvd., West, Suite 400, Silver Spring, Md. 20902</b>   |  | 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |  |
| 32. Registrar's Signature<br><b>B. Sparks</b>                             |   |  |   |  |  |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

00 30309

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AMADO R. BORROMEJO JR.

2. Date of Death

September 11 2000

Day

Year

3. Time of Death

3:15 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

480-06-0946

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 30, 1934

9. Birthplace (State or Foreign Country)

PHILIPPINES

Usual Residence of Decedent

10a. State

NE.

10b. County

DOUGLAS

10c. City, Town or Location

OMAHA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3019 PACIFIC ST.

10f. Zip Code

68105

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: ASIAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PRODUCTION LINE WORKER

16b. Kind of Business/Industry

FROZEN FOODS

17. Father's Name (First, Middle, Last)

AMADO BORROMEJO SR.

18. Mother's Name (First, Middle, Maiden Surname)

BARBARA RAYMONDO

19a. Informant's Name/Relationship (Type, Print)

PAULINE B. BORROMEJO/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

9/12/00

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers

22. Name and Address of Facility

MO0091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cholangitis

Due to (or as a consequence of):

b. Pancreatic cancer

Due to (or as a consequence of):

c. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Days

Weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, cerebrovascular disease, Metabolic acidosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alan S. Chanales MD

29c. License number

29453

29d. Date signed (Month, Day, Year)

September 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN S. CHANALES 15215 SHADY GROVE RD ROCKVILLE MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7

10-10-01

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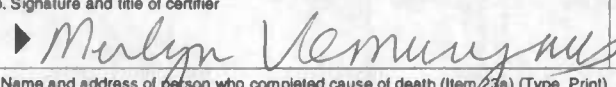
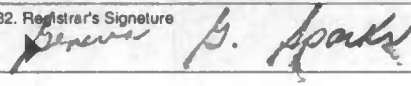
10-10-01

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State of Maryland / Department of Health and Mental Hygiene 00 30310

## Certificate of Death

Reg. No.

|   |  |  |  |   |  |   |  |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Helen E. Blandford   |  |  |   | 2. Date of Death<br>Month Day Year<br>September 8, 2000  |   |  |  | 3. Time of Death<br>10:15 PM                                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Bethesda  |  |  |   | 4b. City, Town, or Location of Death<br>Bethesda   |   |  |  | 4c. County of Death<br>Montgomery                                |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-84-4108   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>101 Yrs.   |   | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.                                   |  |
|   | 8. Date of Birth (Month, Day, Year)<br>February 25, 1899   |  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.   |   | 10a. State<br>Maryland   |   | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Derwood                           |  |
| To Be Completed by<br>Funeral Director  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>6700 Olde Mill Court   |   |  |   | 10f. Zip Code<br>20855   |  | 10g. Citizen of What Country?<br>United States                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7   |  | College (1-4 or 5+) -  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |   |  |  | 16b. Kind of Business/Industry<br>Own Home                       |  |
|   | 17. Father's Name (First, Middle, Last)<br>E.O. Henderson  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ida May Cowell  |   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Myrtle B. Parker/ Daughter   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6700 Olde Mill Court, Derwood, Maryland 20855   |   |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery  |   | Date<br>September 13, 2000   |   | 20c. Location - City or Town, State<br>Silver Spring, Maryland   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br> M00689   |  | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Rockville, Inc. 300 West Montgomery Avenue,<br>Rockville, Maryland 20850-2805  |   |  |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | a. Pneumonia<br>Due to (or as a consequence of):   |   | b. Due to (or as a consequence of):  |   | c. Due to (or as a consequence of):  |  | d. Due to (or as a consequence of):                              |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br> |  | 29c. License number<br>D35791   |  | 29d. Date signed (Month, Day, Year)<br>September 11, 2000 |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Merlyn K. Vemury, M.D. 9801 Georgia Avenue. #227, Silver Spring, MD 20902   |  | 31. Date filed (Month, Day, Year)<br>SEP 12 2000   |  | 32. Registrar's Signature<br> |  |   |  |  |  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 30311

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT M. BENNETT</b>                       |  |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>8</b> Year <b>2000</b> |   | 3. Time of Death<br><b>0855</b>                              |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>                  |   | 4c. County of Death<br><b>MONTGOMERY</b>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-40-2840</b>  |  | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                         |   | 6. Date of Birth (Month, Day, Year)<br><b>March 15, 1927</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                          |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>   |   | 10c. City, Town or Location<br><b>Kensington</b>             |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>4907 Bangor Drive</b>   |  | 10f. Zip Code<br><b>20895</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>World War II</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (14 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Research Economist</b>   |  | 16b. Kind of Business/Industry<br><b>U.S.D.A.</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Benjamin H. Bennett</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Rhodes</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charlene G. Bennett/Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4907 Bangor Drive, Kensington, Maryland 20895</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>  |  | 20c. Date<br><b>Sept. 11 2000</b>  |  | 20d. Location - City or Town, State<br><b>Rockville, Maryland</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Michael E. Perry</b> M00803   |  |  |
| 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>                    |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PERFORATION GASTRIC ULCER</b><br><b>CHRONIC LYMPHOCYTIC LEUKEMIA</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                             |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |
| 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>no.</b>   |  |  |
| 29c. License number<br><b>015236</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 8, 2000</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CALL I. MARGOLIS, M.D. 1125 Rockville Pike, Rockville, MD 20852</b>   |  | 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>   |  |  |
| 32. Registrar's Signature<br><b>B. Sparks</b>  |  | 33. State Registrar  |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020  |  | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30312

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Elmer G. Barth                         |  |  |  | 2. Date of Death<br>Month Day Year<br>September 6, 2000 |  | 3. Time of Death<br>4:40 AM                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1100 Notley Road |  |  |  | 4b. City, Town, or Location of Death<br>Colesville      |  | 4c. County of Death<br>Montgomery                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>168-01-8689   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>85 Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br>May 24, 1915 |  |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                           |  | 10a. State<br>Maryland   |  | 10b. County<br>Montgomery                               |  | 10c. City, Town or Location<br>Colesville           |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>1100 Notley Road   |  | 10f. Zip Code<br>20904   |   | 10g. Citizen of What Country?<br>USA   |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Engineer  |  | 16b. Kind of Business/Industry<br>Electrical   |   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Gustav Barth   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Paulina Ujack   |  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Patricia Barth / Daughter   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7333 Piney Branch Road, Takoma Park, MD 20912   |  |  |   |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rock Creek Cemetery  |  | 20c. Date<br>09/09/00  |   | 20d. Location - City or Town, State<br>Washington, DC                                |   |  |
| 21. Signature of Funeral Service Licensee   |  | 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904  |  |  |   |  |   |  |
| 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |  |   |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. CORONARY ARTERY DISEASE   |  | Due to (or as a consequence of):   |  |  |   | Approximate Interval Between Onset and Death<br>1 YEAR                               |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Renal FAILURE  |  | Due to (or as a consequence of):   |  |  |   | 1 YEAR   |   |  |
| c.  |  | Due to (or as a consequence of):   |  |  |   |  |   |  |
| d.  |  | Due to (or as a consequence of):   |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |  |
|   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br>M  |  | 28b. Time of injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>B. G. Barth MD  |  | 29c. License number<br>D32059  |   | 29d. Date signed (Month, Day, Year)<br>9/6/2000                                      |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael Barth, MD   |  | 11161 New Hampshire Ave., #201, Silver Spring, MD  |  | 20901  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>SEP 11 2000  |  | 32. Registrar's Signature<br>B. Sparks   |  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner




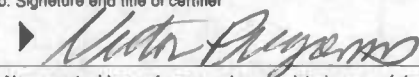

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State of Maryland / Department of Health and Mental Hygiene

00 30313

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |   |  |  |  |  |
|--|---|--|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Anthony J. Baldassarri  |  |   |  |  | 2. Date of Death<br>Month Day Year<br>September 7, 2000   |  | 3. Time of Death<br>12:40 AM   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Suburban Hospital   |  |   |  |  | 4b. City, Town, or Location of Death<br>Bethesda  |  | 4c. County of Death<br>Montgomery  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>154-20-6206  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>72 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>February 6, 1928                              |  | 9. Birthplace (State or Foreign Country)<br>New Jersey |  |
|  | Usual Residence of Decedent   |  |   |  |  |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Virginia  |  | 10b. County<br>Prince William   |  | 10c. City, Town or Location<br>Bristow   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>8857 Tenbury Court  |  |   |  | 10f. Zip Code<br>20136   |   | 10g. Citizen of What Country?<br>United States                                       |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Conflict  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Defense Contractor  |   |  | 16b. Kind of Business/Industry<br>United States Government   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Arturo Baldassarri   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Maria Tese   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Tricia Baldassarri/Daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>507 4th Street, S.E., Washington, D.C. 20003  |   |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Montgomery Crematorium, Inc.  |  |  | Data<br>Sept. 9, 2000   |  | 20c. Location - City or Town, State<br>Bethesda, Maryland  |  |  |
|  | 21. Signature of Funeral Service Licensee<br> M00672  |  |   |  | 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Rockville, Inc., 300 West Montgomery Avenue,<br>Rockville, Maryland 20850-2805   |   |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. Bacterial Pneumonia<br>Due to (or as a consequence of):<br>b. Malignant Ganglio Glioma Right<br>Due to (or as a consequence of):<br>c. Frontal Region<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>72 Hours<br>20 Months |  |   |  |  |   |  |  |  |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Ischemic Heart Disease   |  |   |  |  |   |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |   |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                      |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |  |   |  | 29c. License number<br>D23308  |   | 29d. Date signed (Month, Day, Year)<br>September 7, 2000                             |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Victor M. Priego, M.D., 6410 Rockledge Drive, #625, Bethesda, Maryland 20817   |   |  |   |  |  |   |  |  |  |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br>SEP 12 2000  |  | 32. Registrar's Signature<br>   |  |  |   |  |  |  |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 30314

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Isabella Jacqueline Coyle

2. Date of Death

Month Day Year  
September 8, 2000

3. Time of Death

1015am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

212-38-3666

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 6, 1936

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Spencerville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1225 Spencerville Rd.

10f. Zip Code

20868

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive Assistant

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Raymond Wells Hallock Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Flora Wilson McGuinn

19a. Informant's Name/Relationship (Type, Print)

Judith Carter /Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1225 Spencerville Rd, Spencerville, MD 20868

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Data

Sep 11  
2000

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly P. Hallock

22. Name and Address of Facility

Rapp Funeral & Cremation Services  
933 Gist Avenue Silver Spring, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Gastrointestinal Bleeding

Due to (or as a consequence of):

b. Duodenal Ulcer Gastritis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Anticoagulation

Due to (or as a consequence of):

d. End stage renal disease

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes, hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

MM

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ajay Reddy, MD

29c. License number

D0053691

29d. Date signed (Month, Day, Year)

September 08, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ajay Reddy M.D. 1500 Forest Glen Dr, Silver Spring, MD 20910

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





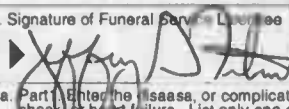
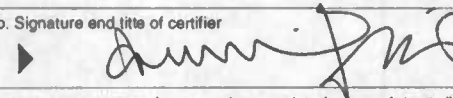

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30315

## Certificate of Death

Reg. No.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>NINOTCHKA COSTA</b>                         |   | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>8</b> Year <b>2000</b> |   | 3. Time of Death<br><b>07:01 PM</b>      |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                  |   | 4c. County of Death<br><b>Montgomery</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-04-9191</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.                         | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.           |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 5, 1958</b>                                |   | 9. Birthplace (State or Foreign Country)<br><b>Brazil</b>                |   |  |
| Usual Residence of Decedent   |  |   |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Potomac</b>   |  |
| 10e. Street and Number<br><b>11212 Angus Place</b>  |  | 10f. Zip Code<br><b>20854</b>   |  | 10g. Citizen of What Country?<br><b>Brazil</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Brazilian</b> |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>-</b> College (1-4 or 5+) <b>4</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>  |  |
| 16b. Kind of Business/Industry<br><b>Brazilian Government</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Manoelito M. Dos Santos</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Yolanda M. Caiafa</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ronaldo P. Costa/ Husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11212 Angus Place, Potomac, MD 20854</b>  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00689</b>  |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>ANOXIC ENCEPHALOPATHY</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b> |  | Approximate Interval Between Onset and Death<br><b>6 days</b>   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>M</b>  |  | 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><br><b>Aravjvanshi MD</b>   |  | 29c. License number<br><b>D37891</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 8 2000</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ARAVJVANSHI MD 121 Congressional Ln #409 Rockville, MD 20852.</b>  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>   |  | 32. Registrar's Signature<br><br><b>B. Sparks</b>   |  |   |  |

11/11/58

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30316

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Helen Gage Conture

2. Date of Death

Month Day Year  
September 13, 2000

3. Time of Death

4:00pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Nursing Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

267-18-7069

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 3, 1919

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Damascus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10176 Shell Drake Circle

10f. Zip Code

20872

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Legal Secretary

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

Nathaniel Gage

18. Mother's Name (First, Middle, Maiden Surname)

Lena Elliot

19a. Informant's Name/Relationship (Type, Print)

Lorie L. Conture (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10176 Shell Drake Circle, Damascus, MD 20872

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

9/14/00

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Arrhythmia

Minutes

Due to (or as a consequence of):

b. Hypoxemia

Weeks

Due to (or as a consequence of):

c. Progressive Pulmonary Fibrosis

Months

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

Congestive Heart Failure

Scoliosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D41794

29d. Date signed (Month, Day, Year)

September 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. Callahan-Lyon, MD 911 Russell Avenue, Gaithersburg, MD 20879

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30317

Certificate of Death

Reg. No.

|  |  |   |  |  |  |   |  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LENA YETT COLODNY</b>                                       |   |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 7, 2000</b> |   |  |  | 3. Time of Death<br><b>11:35 PM</b>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>HEBREW HOME OF GREATER WASHINGTON</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>       |   |  |  | 4c. County of Death<br><b>MONTGOMERY</b>                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>008-24-4086</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (in yrs. last birthday)<br><b>97</b> Yrs.               |   | 8. Date of Birth (Month, Day, Year)<br><b>MAY 28, 1903</b> |  | 9. Birthplace (State or Foreign Country)<br><b>VERMONT</b> |  |
|  | Usual Residence of Decedent  |   |  |  |  |   |  |  |  |  |
| 10a. State<br><b>N/A</b>   |  | 10b. County   |  | 10c. City, Town or Location<br><b>WASHINGTON, D.C.</b>   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>3003 VAN NESS STREET, APT#W618, NW</b>  |  |   |  | 10f. Zip Code<br><b>20008</b>  |  |   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESPERSON</b>  |  |   |  | 16b. Kind of Business/Industry<br><b>RETAIL</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>HARRIS YETT</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EDITH ALICE LEVITAN</b>  |  |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>EDWIN COLODNY/SON</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8225 BURNING TREE ROAD, BETHESDA, MARYLAND 20817</b>                                     |  |   |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HEBREW HOLY SOCIETY CEMT</b>   |  | Date<br><b>SEP 10, 2000</b>  |  | 20c. Location - City or Town, State<br><b>SOUTH BURLINGTON, VT</b>                          |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>EDWARD SAGEL FUNERAL DIRECTION, INC.<br/>1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>   |  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>SEPSIS</b><br><b>PERIPHERAL VASCULAR DISEASE</b><br><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death |  |   |  |  |  |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>Gregory A. Compton MD</b>   |  | 29c. License number<br><b>D24942</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>09/08/2000</b>                                    |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GREGORY A. COMPTON MD 6121 MONTROSE Rd Rockville MD</b>   |  |   |  |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |  | 32. Registrar's Signature<br><b>Barbara B. Sparks</b>   |  |  |  |   |  |  |  |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30318

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joan Teresa Carter

2. Date of Death  
Month Day Year  
September 10, 2000 9:30 pm

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-40-1165

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 11, 1931

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13303 Adams Place Apt #203

10f. Zip Code

20708

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

James McAuliffe

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Flanagan

19a. Informant's Name/Relationship (Type, Print)

Mary K. Carter / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13303 Adams Place Apt #203, Laurel, MD 20708

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

9/14/00

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

Andrew J. Cole

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Renal Failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

4 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease

Gangrene Right Foot

Diabetes Mellitus type I

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Paul A. DeVore

29c. License number

D01852

29d. Date signed (Month, Day, Year)

September 11, 2000

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30319

AMEND#19A PER F.H. G787 9-28-2000 JAB

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Zelda Carof

2. Date of Death

September 12, 2000

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

5501 Southwick St.

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

136-32-2926

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 3, 1910

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5501 Southwick St

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☒ Yes ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Naval Officer

16b. Kind of Business/Industry

United States Navy

17. Father's Name (First, Middle, Last)

Wolf Carof

18. Mother's Name (First, Middle, Maiden Surname)

Lena Davidow

19a. Informant's Name/Relationship (Type, Print)

Sarah Ezzent / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6050 California Circle, #408, Rockville, MD 20852

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem. 09/15/00 Arlington, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Danzansky Goldberg Memorial Chapel

1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Pneumonia

Approximate Interval Between Onset and Death

1 week

b.

Due to (or as a consequence of):

Alzheimer's Disease

&gt;8 years

c.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Osteoporosis

Basal Cell Skin Cancer - Leg

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Group Home

27. Manner of Death

☒ Natural ☐ Accident ☐ Suicide ☐ Homicide  
☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35579

29d. Date signed (Month, Day, Year)

9/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan J. Miller, M.D. 6844 Tulip Hill Terrace Bethesda, MD 20816

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 + 1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30320

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Sylvester Colliflower, Jr.

2. Date of Death

September 11, 2000

3. Time of Death

11:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

College View Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

213-12-7299

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 29, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

110 Burgess Hill Way

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1959-  
197613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

U.S. Airforce

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

Howard S. Colliflower, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Summers Joy Colliflower

19a. Informant's Name/Relationship (Type, Print)

Harry Philip Krantz, step-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4486 Willowtree Drive, Middletown, MD 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resthaven Memorial Gardens

Date

9/14/2000

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Richard C.C. Basford M00021

22. Name and Address of Facility

Keeney and Basford Funeral Home  
106 East Church Street, Frederick, MD 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. CARCINOMA LARYNX  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Richard C.C. Basford MD

29c. License number

D22037

29d. Date signed (Month, Day, Year)

9/12/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L KINCAND 610 NINTH AVE BRUNSWICK MD

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

Geneva B. Spivey

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30321

## Certificate of Death

Reg. No.

|   |   |   |  |  |   |  |  |   |
|---|---|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LEE ROY FRANKLIN CORNETT</b>                             |   |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPT 07 2000</b> |  | 3. Time of Death<br><b>1030 AM</b>                             |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>   |  | 4c. County of Death<br><b>HOWARD</b>                           |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-88-0631</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>32</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 4, 1967</b>                                     |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent   |   |  |  |   |  |  |   |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Woodbine</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
| 10e. Street and Number<br><b>2655 Florence Road</b>   |   |   |  | 10f. Zip Code<br><b>21797</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Data Management</b>  |   | 16b. Kind of Business/Industry<br><b>Computer</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Lee Roy Cornett</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Barbara Eader</b>  |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Cornett / Mother</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2655 Florence Road, Woodbine, Maryland 21797</b>   |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Poplar Springs Cemetery</b>  |  | 20c. Date<br><b>9/10/00</b>  |   | 20d. Location - City or Town, State<br><b>Mt. Airy, Maryland</b>                               |  |   |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Olin L. Molesworth P. A. Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872</b>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |   |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)   |   | a. <b>ASPIRATION PNEUMONIA</b>  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>14 DAYS</b> |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   | b. <b>CENTRAL NERVOUS SYSTEM LYMPHOMA</b>   |  |  |   |  | <b>6 MONTHS</b>  |   |
|   |   | c. <b>ACQUIRED IMMUNODEFICIENCY SYNDROME</b>  |  |  |   |  | <b>5 YEARS</b>   |   |
|   |   | d. <b></b>  |  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MALNUTRITION, AIDS WASTING SYNDROME</b><br><b>PROGRESSIVE MULTIFOCAL LEUCOENCEPHALOPATHY</b>   |   |   |  |  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred                           |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D42892</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>SEPT 07 2000</b>                                     |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRANCIS CHVIDIAN 10724 LITTLE PATUXENT PARKWAY COLUMBIA MD 21044</b>   |   |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |   | 32. Registrar's Signature<br>   |  |  |   |  |  |   |

ORIGINAL

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00 30322

Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |   |  |
|--|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>HARRY LEO CAREY                             |   |  |  | 2. Date of Death<br>Month Day Year<br>SEPT 11 2000 |  | 3. Time of Death<br>9:45 PM                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>19435 NATIONAL HWY NW |   |  |  | 4b. City, Town, or Location of Death<br>FROSTBURG  |  | 4c. County of Death<br>ALLEGANY                     |  |
| Funeral<br>Director  | 5. Social Security Number<br>214-07-6821  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>82 Yrs.          |  | 8. Date of Birth (Month, Day, Year)<br>JAN 15, 1918 |  |
|  | 9. Birthplace (State or Foreign Country)<br>MARYLAND                                    |   | 10. State<br>MARYLAND  |  | 10b. County<br>ALLEGANY                            |  | 10c. City, Town or Location<br>FROSTBURG            |  |
| 10e. Street and Number<br>19435 NATIONAL HWY NW  |   | 10f. Zip Code<br>21532  |  | 10g. Citizen of What Country?<br>USA   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 College (1-4 or 5+)   |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>TRUCK DRIVER  |  | 16b. Kind of Business/Industry<br>TRUCKING   |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>JOHN LAWRENCE CAREY   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ROSE ANN SMITH  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>SHARON M. CAREY DAUGHTER   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>19435 NATIONAL HWY NW, FROSTBURG, MD 21532  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>FROSTBURG MEMORIAL PARK   |  | 20c. Date<br>SEPT 15, 2000   |  | 20d. Location - City or Town, State<br>FROSTBURG, MD   |   |  |
| 21. Signature of Funeral Service Licensee<br>Douglas S. Hafer  |   |   |  | 22. Name and Address of Facility<br>HAFER FROST MANSION FUNERAL HOME<br>58 FROST AVE., FROSTBURG, MD 21532                                   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Carcinoma of the prostate with multiple bone metastasis. 14 yrs.<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |   |   |  |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |   |   |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |  |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Myocardial Infarction. 09/21/00-1999   |   |   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury of Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.   |   |   |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br>Chang Hyun Oh, M.D.   |   |   |  | 29c. License number<br>D24951  |  | 29d. Date signed (Month, Day, Year)<br>09/13/00  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Chang Hyun Oh, M.D., 48 Tarn Terrace, Suite 204, Frostburg, Md. 21532  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>SEP 14 2000   |   |   |  | 32. Registrar's Signature<br>[Signature]   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 30323

|   |   |                        |   |   |  |   |  |  |  |  |
|---|---|------------------------|---|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>ETHEL VIOLA CLOSTERMAN                      |                        |   |   |  |   | 2. Date of Death<br>Month Day Year<br>September 15 2000                              |  | 3. Time of Death<br>8:35 AM                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>SACRED HEART HOSPITAL |                        |   |   |  |   | 4b. City, Town, or Location of Death<br>CUMBERLAND                                   |  | 4c. County of Death<br>ALLEGANY                      |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-05-6238  |                        | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>97 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>OCT 22 1902                                   |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND |  |
|   | Usual Residence of Decedent   |                        |   |   |  |   |  |  |  |  |
| 10a. State<br>PA.   |   | 10b. County<br>BEDFORD |   | 10c. City, Town or Location<br>BEDFORD  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
| 10e. Street and Number<br>1122 DARK HOLLOW ROAD   |   |                        |   | 10f. Zip Code<br>15522  |  | 10g. Citizen of What Country?<br>U.S.A.                             |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+)   |   |                        |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>WAITRESS/RESTAURANT          |  |   | 16b. Kind of Business/Industry<br>WAITRESS   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>GEORGE ENTLER  |   |                        |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>ELSIE ROBINSON |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>KATHRYN CESSNA DAUGHTER   |   |                        |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1122 DARK HOLLOW ROAD, BEDFORD PA. 15522 |  |   |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>REST LAWN CEMETERY SEPT 18 2000   |   |  | 20c. Location - City or Town, State<br>LAVALLE MARYLAND             |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>Dale L. Merritt  |   |                        |   | 22. Name and Address of Facility<br>MERRITT-ADAMS FUNERAL HOME P.A.<br>404 DECATUR STREET CUMBERLAND MARYLAND                             |  |   |  |  |  |  |
| 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |                        |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death |
| Immediate Cause (Final disease or condition resulting in death)<br>a. Aspiration Pneumonia<br>Due to (or as a consequence of):  |   |                        |   |   |  |   |  |  |  | 7 days                                       |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. CHF - A. Fibrillation<br>Due to (or as a consequence of):  |   |                        |   |   |  |   |  |  |  |  |
| c. Dehydration<br>Due to (or as a consequence of):  |   |                        |   |   |  |   |  |  |  |  |
| d.  |   |                        |   |   |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>old age with legal blindness  |   |                        |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|   |   |                        |   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|   |   |                        |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                        | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                        | 29b. Signature and title of certifier<br>John Mehanna M.D.  |   |  | 29c. License number<br>D-17526                                      |  | 29d. Date signed (Month, Day, Year)<br>September 15, 2000  |  |  |
| 30. Name and address of person who completed cause of death (Item 23d) (Type, Print)<br>John Mehanna M.D. 902 Seton Drive Cumberland MD 21502   |   |                        |   |   |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 15 2000  |   |                        | 32. Registrar's Signature<br>Benjamin B. Sparks   |   |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30324

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LINDA JEAN DOMBRADY

2. Date of Death

Month Day Year  
SEPT. 7, 2000

3. Time of Death

11:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7706 HANOVER PARKWAY #102

4b. City, Town, or Location of Death

GREENBELT

4c. County of Death

PRINCE GEORGES

5. Social Security Number

557-68-7178

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 25, 1947

9. Birthplace (State or Foreign Country)

OHIO

Usual Residence of Decedent

10a. State

MD.

10b. County

PRINCE GEORGES

10c. City, Town or Location

GREENBELT

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7706 HANOVER PARKWAY #102

10f. Zip Code

20770

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FINANCIAL PLANNER

16b. Kind of Business/Industry

FINANCIAL SERVICES INC.

17. Father's Name (First, Middle, Last)

JULIUS A. DOMBRADY

18. Mother's Name (First, Middle, Maiden Surname)

BLANCHE L. YENERALL

19a. Informant's Name/Relationship (Type, Print)

BLANCHE L. DOMBRADY/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

9/8/00

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers

22. Name and Address of Facility

M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BRONCHIOGENIC CARCINOMA -

Approximate Interval Between Onset and Death

59 YEARS

Due to (or as a consequence of):

b. METASTATIC BRONCHIOGENIC CANCER

54 YEARS

Due to (or as a consequence of):

c. NEUTROPENIA

6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NON INSULIN DEPENDENT DIABETES MELLITUS

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary Ruth Lopez

29c. License number

D46834

29d. Date signed (Month, Day, Year)

9-8-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY RUTH LOPEZ, M.D. 7525 GREENWAY CENTER DR. #113, GREENBELT, MD.

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

G. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

10:00 AM

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10:00 AM



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30325

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Teresa M. Darter

2. Date of Death

September 8, 2000

3. Time of Death

1:45 PM

4a. Facility Name (If not institution, give street and number)

5705 Luxemburg Street, #400

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

286-52-1396

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

February 28, 1955

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5705 Luxemburg Street, #400

10f. Zip Code

20852

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Computer Systems Specialist

16b. Kind of Business/Industry

United States  
Government

17. Father's Name (First, Middle, Last)

Thomas O. Darter

18. Mother's Name (First, Middle, Maiden Surname)

Iona L. Hephner

19a. Informant's Name/Relationship (Type, Print)

Linda K. Andrade/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6511 Tartan Vista Dr., Alexandria, VA 22312

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

September

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service

M00689

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Generalized Carcinomatosis

1 week

Due to (or as a consequence of):

b. Metastatic Head and Neck Cancer

1 1/2 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D45274

29d. Date signed (Month, Day, Year)

September 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cho Maung, M.D. 10810 Connecticut Avenue, Kensington, MD 20895

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12






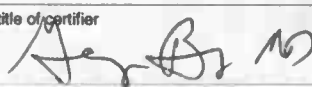
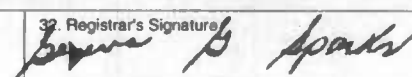
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30326

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|---|--|---|---|---|--|--|---|--|---|---|----|-------------------|--|----------------------------------|--|----|----------------------------------|----------------------------------|--|--|----|--|-------|----------------------------------|--|----|--|----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ellen Elizabeth Diehl</b>                       |   |   |   |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>09</b> Year <b>2000</b> |  | 3. Time of Death<br><b>21:05 hrs</b>                        |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sacred Heart Hospital</b> |   |   |   |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>                 |  | 4c. County of Death<br><b>Allegany</b>                      |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-46-4808</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>05-Apr-10</b>                   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|   | Usual Residence of Decedent  |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Allegany</b>  |   | 10c. City, Town or Location<br><b>Frostburg</b>   |  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 10e. Street and Number<br><b>100 Honeysuckle Lane<br/>Apt. #218</b>   |  |   |   | 10f. Zip Code<br><b>21532-</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b> |  |  | 16b. Kind of Business/Industry<br><b>homemaker</b>                        |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Pary</b>  |  |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sarah Carpenter</b>  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Frank Diehl son</b>  |  |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3001 Woodville Road Lewisville North Carolina 27023-</b> |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fairview Cemetery</b>                            |  | Date<br><b>13-Sep-00</b>   |   | 20c. Location - City or Town, State<br><b>Artemas, Pennsylvania</b>  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   |   |  | 22. Name and Address of Facility<br><b>Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532</b>  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Septicemia</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>1 day</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>Potable urinary infection</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td rowspan="4">1 day</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> </table> |  |   |   |   |  |  |   |  |   | Immediate Cause (Final disease or condition resulting in death) | a. | <b>Septicemia</b> | Approximate Interval Between Onset and Death<br><b>1 day</b> | Due to (or as a consequence of): |  | b. | <b>Potable urinary infection</b> | Due to (or as a consequence of): |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. |  | 1 day | Due to (or as a consequence of): |  | d. |  | Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)   | a.   | <b>Septicemia</b>   | Approximate Interval Between Onset and Death<br><b>1 day</b>  |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|   | Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|   | b.   | <b>Potable urinary infection</b>  |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|   | Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | c.   |   | 1 day   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|   | Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|   | d.   |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
|   | Due to (or as a consequence of):   |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension      Diverticulitis</b><br><b>Arteriosclerosis</b><br><b>Osteoarthritis</b>   |  |   |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D12532</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>September 11, 2000</b>   |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>George Breza, M.D., 912 Seton Drive, Cumberland, Maryland 21502</b>  |  |   |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>   |  | 32. Registrar's Signature<br>  |   |   |  |  |   |  |   |   |    |                   |  |                                  |  |    |                                  |                                  |  |  |    |  |       |                                  |  |    |  |                                  |  |

ORIGINAL

Handwritten notes or signatures at the bottom of the page.

2000 September 09, 2000  
2133-122  
Allegany  
Cumberland  
Wayland  
02-Apr-10  
Wayland  
20  
230-44-1808  
Wayland  
Allegany  
100 Honeycreek Lane  
Vbl. #218  
Frostburg  
2133-  
U.S.A.  
White  
Homemaker  
Zachary Carpenter  
3001 Woodville Road  
Lewisville  
North Carolina 27033  
13-Sep-00  
Atlanta, Pennsylvania  
Dust Funeral Home, 27 Post Ave., Frostburg, MD 21332  
Frostburg Cemetery

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30327

Amended Item#5 per INF G788 10/19/2000 EW

## Certificate of Death

Reg. No.

|  |   |                                  |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|--|---|----------------------------------|--|---|--|--|--|--|---|----|------------------|--|----|----------------------------------|----|----------------------------------|----|----------------------------------|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE WILHELM EILERS</b>  |                                  |  |   | 2. Date of Death<br>Month Day Year<br><b>AUG 30 2000</b>   |  | 3. Time of Death<br><b>12:40 A.M.</b>  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>  |                                  |  |   | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| Funeral<br>Director  | 5. Social Security Number<br><b>150-07-4339</b>   |                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>84</b>  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug 15 1916</b>  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>   |                                  | 10e. State<br><b>MD</b>  |   | 10b. County<br><b>Prince Georges</b>   |  | 10c. City, Town or Location<br><b>Temple Hills</b>   |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |                                  |  |   | 10f. Zip Code<br><b>20748</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |                                  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1933-1961</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>  |                                  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Soldier</b>  |  | 16b. Kind of Business/Industry<br><b>Military</b>  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Wilhem Louis Eilers</b>  |                                  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Dunlag</b>  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Lillian Nadine Chamblee</b>  |                                  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3501 27th Ave., Temple Hills, Md 20748</b>                         |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                                  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Geo. Wash. Medical Ctr.</b>   |  | 20c. Location - City or Town, State<br><b>Washington DC</b>  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 21. Signature of Funeral Service Licensee<br>   |                                  |  |   | 22. Name and Address of Facility<br><b>Columbia Mortuary Services<br/>P.O. Box 58007, Washington DC 20037</b>  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                                  |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>PNEUMONIA</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table> |                                  |  |   |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>PNEUMONIA</b> | Approximate Interval Between Onset and Death | b. | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d. | Due to (or as a consequence of): |
|  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.                               | <b>PNEUMONIA</b>   | Approximate Interval Between Onset and Death  |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| b.   |   | Due to (or as a consequence of): |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| c.   |   | Due to (or as a consequence of): |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| d.   |   | Due to (or as a consequence of): |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                  |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |                                  |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                  |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                                  |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                                  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |                                  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  |   |                                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
|  |   |                                  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                                  |  |   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 29b. Signature and title of certifier<br>  |   |                                  |  | 29c. License number<br><b>MD D0054504</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Aug 30, 2000</b>                   |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>LUTHER CARTER LT, MC, USNR</b>  |   |                                  |  | <b>BETHESDA, MD 20889-5600</b>  |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |   |                                  |  | 32. Registrar's Signature<br>   |  |  |  |  |   |    |                  |  |    |                                  |    |                                  |    |                                  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30328

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HAROLD

2. Date of Death

EBERSOLE

SEPTEMBER 7, 2000

3. Time of Death

12:48p

4a. Facility Name (If not institution, give street and number)

11038 Montgomery Road

4b. City, Town, or Location of Death

Beltsville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

219-34-8547

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

June 26, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11038 Montgomery Road

10f. Zip Code

20705

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
unk

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Motor Vehicle Inspector

16b. Kind of Business/Industry

Washington, D.C. Dept.  
of Motor Vehicles

17. Father's Name (First, Middle, Last)

Paul Henry Ebersole

18. Mother's Name (First, Middle, Maiden Surname)

Retta Sophia Keckler

19a. Informant's Name/Relationship (Type, Print)

Mary Ellen Ebersole (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory 9/9/2000

Date

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Matthew J. Brown

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. SQUAMOUS CELL CARCINOMA OF NECK

Approximate  
Interval Between  
Onset and Death

3 YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

B. Sparks

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

SEPTEMBER 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PIOTR KULESZA R.D. 600 N. WOLFE ST

BALTIMORE MD.  
21287State  
Registrar

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30329

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Cora Fisler

2. Date of Death

September 8, 2000

3. Time of Death

9:54 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

577-01-8137

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

April 14, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3350 Chiswick Court #3D

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Bernard Clark

18. Mother's Name (First, Middle, Maiden Surname)

Cora E. Drury

19a. Informant's Name/Relationship (Type, Print)

Alma C. Lynch

(sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15300 Pine Orchard Drive Silver Spring, Maryland 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

9/12/00 Silver Spring, Maryland

21. Signature of Funeral Service Licensee

William J. Boyd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23e. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William J. Boyd M.D.

29c. License number

D31908

29d. Date signed (Month, Day, Year)

September 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WALTER D. FERRELL JR., 3305 North Hershey Road, Silver Spring, Maryland 20906

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

Bernard B. Sparks

20906

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30330

Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |  |  |
|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>HELEN EDITH FELDBERG   |  |   |   | 2. Date of Death<br>Month 09 Day 07 Year 2000  |  | 3. Time of Death<br>12:40 PM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>KESWICK MULTICARE CENTER   |  |   |   | 4b. City, Town, or Location of Death<br>BALTIMORE  |  | 4c. County of Death  |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-40-9342   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>80 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>02 05 1920  |  | 9. Birthplace (State or Foreign Country)<br>WASHINGTON, DC |
|  | Usual Residence of Decedent  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>MD   | 10b. County<br>MONTGOMERY  | 10c. City, Town or Location<br>SILVER SPRING  |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>2309 COLSTON DR.   |  |   | 10f. Zip Code<br>20910  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>CO-OWNER                     |  | 16b. Kind of Business/Industry<br>RETAIL GIFT SHOP   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>ABRAHAM BONDAREFF   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>IDA GUREVICH  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>JAN L. FELDBERG DAUGHTER   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2309 COLSTON DR, SILVER SPRING, MD 20910 |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>KING DAVID MEMORIAL GARDENS   |   | 20c. Location - City or Town, State<br>FALLS CHURCH, VA  |  | 20d. Date<br>9-10-2000   |  |
|  | 21. Signature of Funeral Service Licensee<br>Ronald W. Rivenburgh  |  |   | 22. Name and Address of Facility<br>DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852                 |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Diffuse Lewy-Body Dementia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |   |   |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28d. Describe how injury occurred  |  |
|  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |  |  |
| State Registrar  | 29b. Signature and title of certifier<br>Dr. Isabelle MacGregor MD   |  |   | 29c. License number<br>D13657   |  | 29d. Date signed (Month, Day, Year)<br>September 7, 2000   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. ISABELLE MACGREGOR, KESWICK, 700 W. 40th STREET, BALTIMORE, MD 21211   |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 12 2000   |  | 32. Registrar's Signature<br>Geneva B. Sparks                                  |   |   |  |  |  |  |

HELEN FELDBERG

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25

1960 FEBRUARY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30331

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Leo Ellis Fake   |  |  |  | 2. Date of Death<br>Month Day Year<br>September 10, 2000  |  |   |  | 3. Time of Death<br>9:10 pm  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Suburban Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Bethesda  |  |   |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>578-44-1256   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>79 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Oct 14, 1920 |  | 9. Birthplace (State or Foreign Country)<br>New York   |  |
|  | Usual Residence of Decedent  |  |  |  | 10a. State<br>Maryland  |  | 10b. County<br>Montgomery                           |  | 10c. City, Town or Location<br>Bethesda  |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10a. Street and Number<br>9910 Dickens Avenue   |  |   |  | 10f. Zip Code<br>20814   |  |
|  | 10g. Citizen of What Country?<br>USA   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Economist   |  |  |  | 16b. Kind of Business/Industry<br>US Government   |  |   |  | 17. Father's Name (First, Middle, Last)<br>Alonzo D. Fake  |  |
|  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Meehan   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Ann Fake / Wife  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9910 Dickens Avenue, Bethesda, MD 20814   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |  |   |  | 20c. Location - City or Town, State<br>Alexandria, VA  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Francis J. Collins</i>   |  |  |  | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc.<br>500 University Blvd., W, Silver Spring, MD 20901   |  |   |  | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. METASTATIC GASTRIC CARCINOMA<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |
|  | 28a. Date of Injury (Month, Day, Year)   |  |  |  | 28b. Time of Injury<br>M  |  |   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred                |  |  |  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| To Be Completed by<br>Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br><i>Victor Priego</i>   |  |   |  | 29c. License number<br>D23308  |  |
|  | 29d. Date signed (Month, Day, Year)<br>SEPT. 11, 2000  |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>VICTOR M. PRIEGO, MD 6410 ROCKLEDGE DR. #625 BETHESDA, MD 20817   |  |   |  | 31. Date filed (Month, Day, Year)<br>SEP 13 2000   |  |
|  | 32. Registrar's Signature<br><i>B. Sparks</i>  |  |  |  | 33. Date of Death (Month, Day, Year)<br>SEP 10 2000   |  |   |  | 34. Time of Death<br>9:10 pm   |  |

ORIGINAL





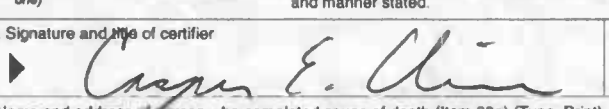
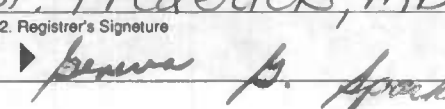
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30332

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN LAVERNE FAWLEY</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>September 12, 2000</b>   |  | 3. Time of Death<br><b>10:20 A.M.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Citizens Nursing Home</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  | 4c. County of Death<br><b>Frederick</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-24-3890</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F             |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 4, 1919</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Potomac</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>12901 Travilah Road</b>  |  | 10f. Zip Code<br><b>20854</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>        |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cafeteria Worker</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Board Of Education</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>John Pavlina</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Tichoufski</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Terry L. Fawley, daughter</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5039 Ijamsville Road Ijamsville, Maryland 21754</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>   |  | 20c. Location - City or Town, State<br><b>09/13/00 Hagerstown, Maryland</b>   |  |
|   | 21. Signature of Funeral Service<br>   |  |  |  | 22. Name and Address of Facility<br><b>Stauffer Funeral Homes, P.A.<br/>1621 Opossumtown Pike Frederick, Maryland 21702</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypertensive Cardiovascular Disease</b><br>Due to (or as a consequence of):  |  |  |  | Approximate Interval Between Onset and Death<br><b>1 year</b>   |  |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.   |  |  |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
|   |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and Title of certifier<br>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D16428</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>9/12/00</b>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>300 W 94th St. Frederick, MD 21701</b>  |  |  |  |   |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>  |  |  |  | 32. Registrar's Signature<br>   |  |   |  |
|   |  |  |  |  |   |  |   |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30333

|  |  |   |  |   |   |  |  |   |  |
|--|--|---|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN J. GURTOWSKI</b>                       |   |  |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 10, 2000</b> |  | 3. Time of Death<br><b>8:50 PM</b>                         |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>         |  | 4c. County of Death<br><b>MONTGOMERY</b>                   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>144-05-9117</b>  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.                |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec 10, 1912</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>                              |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>                                |  | 10c. City, Town or Location<br><b>Bethesda</b>             |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>5921 Avon Drive</b>  |   | 10f. Zip Code<br><b>20814</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                       |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Materials Engineer</b>                                      |  | 16b. Kind of Business/Industry<br><b>Department of the Navy</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>Frank Gurtowski</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Puzio</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Grace Gurtowski, Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5921 Avon Drive, Bethesda, MD 20814</b>                                 |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 E. Deer Park Dr., Gaithersburg, MD 20877</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CORONARY ARTERIOSCLEROSIS</b>   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  | 23c. Approximate Interval Between Onset and Death<br><b>10 YEARS</b>  |  |
| 23d. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>DIABETES</b>   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D42423</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>09/11/00</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>B. ROBERT MOZAYENI, M.D., 5530 WISCONSIN AVENUE, #1208 CHEVY CHASE, MD 20815</b> |  | 31. Date filed (Month, Day, Year)<br><b>SEP 15 2000</b>   |   | 32. Registrar's Signature<br>  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene **00 30334**  
**Certificate of Death**

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Frances Goldberg</b>  |  |   |  | 2. Date of Death<br>Month <b>9</b> Day <b>12</b> Year <b>2000</b>   |  | 3. Time of Death<br><b>1:15pm</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Chevy Chase</b>  |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| 5. Social Security Number<br><b>079-28-7516</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>102 Yrs.</b>   |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 12, 1897</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Russia</b>  |  | 10. Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>Montgomery</b> 10c. City, Town or Location <b>Chevy Chase</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>8700 Jones Mill Road</b>   |  |
| 10f. Zip Code<br><b>20815</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>   |  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Milliner/Hatmaker</b>   |  |
| 16b. Kind of Business/Industry<br><b>Fashion</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Morris Weinberg</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline unk</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rita Segerman (daughter)</b>   |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5600 Wisconsin Ave., #107 Chevy Chase, Maryland 20815</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>United Hebrew Cemetery 9/14/00</b>   |  | 20c. Location - City or Town, State<br><b>Staten Island, N.Y.</b>   |  |
| 21. Signature of Funeral Home Licensee<br><i>[Signature]</i>   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiomyopathy</b><br>Due to (or as a consequence of)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. {</b><br><b>c. {</b><br><b>d. {</b> |  | Approximate Interval Between Onset and Death<br><b>years</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b><br><b>Seizure disorder</b><br><b>NIDDM</b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. Signature and title of certifier<br><b>Ellen M Pinholt MD</b>   |  | 29c. License number<br><b>D 51015</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>Sept 12, 2000</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ellen Pinholt MD 5530 Wisconsin Avenue #1045 Chevy Chase MD 20815</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  | 33. State Registrar   |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30335

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Frances Cruikshank Gewehr

2. Date of Death  
Month Day Year  
September 11, 20003. Time of Death  
8:45pmFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

577-12-1530

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 29, 1920

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

415 Russell Avenue #1111

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Special Asst. Library Congress

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Carey Gordon Cruikshank

18. Mother's Name (First, Middle, Maiden Surname)

Edna Jones

19a. Informant's Name/Relationship (Type, Print)

Wesley H. Gewehr (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3008 N. Underwood Street, Arlington, VA 22213

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

9/12/00 Alexandria, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PRIMARY PERITONEAL CANCER

Approximate Interval Between Onset and Death

13 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph M. Haggerty MD

29c. License number

D32407

29d. Date signed (Month, Day, Year)

SEPTEMBER 12, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph M. Haggerty, MD, 9707 Medical Center Drive, Rockville, MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

00 30336

Reg. No.

|   |  |  |   |  |  |   |  |  |  |  |  |  |  |   |  |
|---|--|--|---|--|--|---|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Thomas Peter Gallagher III                               |  |   |  | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 06, 2000   |   |  |  | 3. Time of Death<br>01:25 A.M.   |  |  |  |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>16th Street ramp to GEORGIA AVENUE |  |   |  | 4b. City, Town, or Location of Death<br>SILVER SPRING  |   |  |  | 4c. County of Death<br>MONTGOMERY  |  |  |  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br>577-1506017   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>21   |   | 8. Date of Birth (Month, Day, Year)<br>Jun. 14, 1979   |  | 9. Birthplace (State or Foreign Country)<br>Wash., D.C.  |  |  |  |  |   |  |
|   | Usual Residence of Decedent  |  |   |  |  |   |  |  |  |  |  |  |  |   |  |
| 10a. State<br>D.C.  |  |  | 10b. County   |  |  | 10c. City, Town or Location<br>Washington, D.C. |  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |   |  |
| 10e. Street and Number<br>2134 Cathedral Avenue NW.   |  |  |   | 10f. Zip Code<br>20008   |  |   |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |  |  |  |  |   |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |  |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>2  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Student |  |   |  | 16b. Kind of Business/Industry<br>Student                        |  |  |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Thomas P. Gallagher  |  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ann Hopkins   |   |  |  |  |  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Thomas P. Gallagher - Father  |  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4104 Military Rd. NW., Wash., D.C. 20015  |   |  |  |  |  |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>National Crematory  |  |  | Date<br>9/13/2000                               |  | 20c. Location - City or Town, State<br>Falls Church, Va.         |  |  |  |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Bernard Delmonico</i>   |  |  |   |  | 22. Name and Address of Facility<br>Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Ave. NW., Washington, D.C. 20016  |   |  |  |  |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. Head Injuries<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |  |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |   |  |
|   |  |  |   |  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  | 28a. Date of Injury (Month, Day, Year)<br>9/6/00  |  | 28b. Time of Injury<br>0120 M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                      |  | 28d. Describe how injury occurred<br>Passenger in auto accident                                    |  |  |  |  |   |  |
|   |  |  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)<br>STREET  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>16th St / Georgia Ave, Silver Spring |  |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   |  |  |   |  |  |  | 29b. Signature and title of certifier<br><i>Robert...</i>  |  | 29c. License number<br>O.C.M.E.  |  | 29d. Date signed (Month, Day, Year)<br>SEPTEMBER 06, 2000 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. A. Fox, M.D. 111 Penn Street, Baltimore, Maryland 21201  |  |  |   |  |  |   |  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>SEP 13 2000  |  |  | 32. Registrar's Signature<br><i>Benjamin B. Sparks</i>  |  |  |   |  |  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30337

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Helen Louise Grove  |  |  |  | 2. Date of Death<br>Month Day Year<br>September 12, 2000   |  | 3. Time of Death<br>11:25 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Northampton Manor Nursing Home  |  |  |  | 4b. City, Town, or Location of Death<br>Frederick  |  | 4c. County of Death<br>Frederick  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>214-28-5583  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>88 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>August 20, 1912  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland   |  | 10b. County<br>Frederick   |  | 10c. City, Town or Location<br>Frederick  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br>27 East Ninth Street   |  | 10f. Zip Code<br>21701  |  |
|   | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+)   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |  |  | 16b. Kind of Business/Industry<br>Own Home   |  | 17. Father's Name (First, Middle, Last)<br>Lewis Leather  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mollie Ricketts  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>William E. Grove/Son   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>27 East Ninth Street, Frederick, Md. 21701   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery  |  | 20c. Date<br>Sept. 15, 2000   |  |
| To Be Completed by Physician/Medical Examiner | 20d. Location - City or Town, State<br>Frederick, Maryland  |  |  |  | 21. Signature of Funeral Service Licensee<br>Richard C. C. Basford   |  | 22. Name and Address of Facility<br>Keeney and Basford Funeral Home<br>106 East Church Street, Frederick, Md. 21701   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Left Lung Bronchogenic Carcinoma 6 months<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)<br>M   |  | 28b. Time of Injury<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Describe how injury occurred   |  |  |  | 28d. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. Signature and title of certifier<br>James S. Grissom, M.D.  |  | 29c. License number<br>D21944   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br>September 13, 2000   |  |  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>James S. Grissom, M.D., 300 West Ninth Street, Frederick, Maryland 21701   |  | 31. Data filed (Month, Day, Year)<br>SEP 14 2000  |  |
|   | 32. Registrar's Signature<br>B. Spack   |  |  |  | 33. State Registrar<br>SEP 14 2000   |  | 34. Original  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



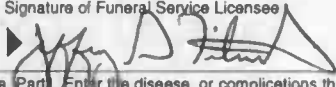
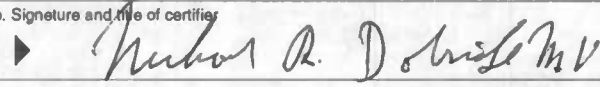
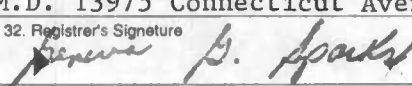
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30338

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |   |                                |  |  |  |
|--|--|--|--|--|---|---|--------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Esther Rebecca Hughes                    |  |  |  |   | 2. Date of Death<br>Month Day Year<br>September 9, 2000 |                                |  | 3. Time of Death<br>5:15 AM              |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Manor Care Wheaton |  |  |  |   | 4b. City, Town, or Location of Death<br>Wheaton         |                                |  | 4c. County of Death<br>Montgomery        |  |
| Funeral<br>Director  | 5. Social Security Number<br>293-16-7176   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>76 Yrs. |   | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.           |  |
|  | 8. Date of Birth (Month, Day, Year)<br>February 3, 1924                              |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                       |  | 10e. State<br>Maryland                    |   | 10b. County<br>Montgomery      |  | 10c. City, Town or Location<br>Rockville |  |
| Usual Residence of Decedent  |  |  |  |  |   |   |                                |  |  |  |
| 10e. Street and Number<br>8 Dorothy Lane   |  |  |  |  |   |   |                                |  |  |  |
| 10f. Zip Code<br>20851   |  |  |  |  |   |   |                                |  |  |  |
| 10g. Citizen of What Country?<br>United States   |  |  |  |  |   |   |                                |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  |  |   |   |                                |  |  |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  |  |  |  |   |   |                                |  |  |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  |  |   |   |                                |  |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |  |  |   |   |                                |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) -  |  |  |  |  |   |   |                                |  |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Computer Operator   |  |  |  |  |   |   |                                |  |  |  |
| 16b. Kind of Business/Industry<br>Computers  |  |  |  |  |   |   |                                |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Marshall Richmond   |  |  |  |  |   |   |                                |  |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Stella Not Available  |  |  |  |  |   |   |                                |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Raymond F. Hughes/ Husband   |  |  |  |  |   |   |                                |  |  |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8 Dorothy Lane, Rockville, Maryland 20851   |  |  |  |  |   |   |                                |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  |  |   |   |                                |  |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cemetery  |  |  |  |  |   |   |                                |  |  |  |
| 20c. Location - City or Town, State<br>Arlington, Virginia   |  |  |  |  |   |   |                                |  |  |  |
| 21. Signature of Funeral Service Licensee<br> M00689   |  |  |  |  |   |   |                                |  |  |  |
| 22. Name and Address of Facility<br>Robert A. Pumphrey Funeral Home/<br>Rockville, Inc. 300 West Montgomery Avenue,<br>Rockville, Maryland 20850-2805  |  |  |  |  |   |   |                                |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Coronary Artery Heart Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |   |   |                                |  |  |  |
| Approximate Interval Between Onset and Death<br>10 years   |  |  |  |  |   |   |                                |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic Obstructive Pulmonary Disease  |  |  |  |  |   |   |                                |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |   |   |                                |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |   |   |                                |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |   |   |                                |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |   |   |                                |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |  |   |   |                                |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |  |   |   |                                |  |  |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |  |   |   |                                |  |  |  |
| 28d. Describe how injury occurred  |  |  |  |  |   |   |                                |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |   |   |                                |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |   |   |                                |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |  |  |  |   |   |                                |  |  |  |
| 29b. Signature and title of certifier<br> M.D.  |  |  |  |  |   |   |                                |  |  |  |
| 29c. License number<br>DO 1138   |  |  |  |  |   |   |                                |  |  |  |
| 29d. Date signed (Month, Day, Year)<br>9-11-2000   |  |  |  |  |   |   |                                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael R. Dobridge, M.D. 13975 Connecticut Avenue, #308, Silver Spring, MD 20906  |  |  |  |  |   |   |                                |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 12 2000   |  |  |  |  |   |   |                                |  |  |  |
| 32. Registrar's Signature<br>  |  |  |  |  |   |   |                                |  |  |  |

1500



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State of Maryland / Department of Health and Mental Hygiene

00 30339

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Harriet B. Hopkinson</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>September 8, 2000</b>   |  | 3. Time of Death<br><b>9:30 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Rebecca House</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Potomac</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-38-2065</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 6, 1909</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Wisconsin</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Potomac</b>  |  |
| To Be Completed by Funeral Director           | 10a. Street and Number<br><b>9910 River Road</b>   |  |   |  | 10f. Zip Code<br><b>20854</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (14 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>  |  | 16b. Kind of Business/Industry<br><b>Montgomery County Public Schools</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Paul L. Biersach</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eulalia Julian</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan H. Stajdohar/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1249 W. Jefferson Avenue, Naperville, Illinois 60540</b>                                 |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>   |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>   |  | 20d. Date<br><b>Sept. 12, 2000</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br> <b>M00198</b>  |  |   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>                                  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br>Due to (or as a consequence of):<br><b>Chronic Lymphocytic Leukemia</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Chronic Lymphocytic Leukemia</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>3 Days</b><br><br><b>Years</b> |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Severe Dementia</b>   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Group Home</b> |  |  |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>D35579</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 11, 2000</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Susan J. Miller, M.D. 6844 Tulip Hill Terrace, Bethesda, Maryland 20816</b>   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |
|   | State Registrar  |  |   |  |  |  |  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 30340

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Marian K. Hooker  |  |   |  | 2. Date of Death<br>Month Day Year<br>September 5, 2000   |  | 3. Time of Death<br>745am   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Brighton Gardens at Friendship  |  |   |  | 4b. City, Town, or Location of Death<br>Chevy Chase   |  | 4c. County of Death<br>Montgomery   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>579-62-9570  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>96 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Feb 29, 1904   |  |
|   | 9. Birthplace (State or Foreign Country)<br>PA  |  | 10a. State<br>DC  |  | 10b. County<br>Washington, DC   |  | 10c. City, Town or Location<br>Washington, DC   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br>2500 Massachusetts Ave  |  |   |  | 10f. Zip Code<br>20008  |  | 10g. Citizen of What Country?<br>United States  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home  |  |
|   | 17. Father's Name (First, Middle, Last)<br>William S. Kuhn  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Kate Hill  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Catherine Herter / Daughter   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1525 28Th St. NW, Washington, DC 20007   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | 20c. Location - City or Town, State<br>Beltsville, MD   |  | 20d. Date<br>Sep 7 2000   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Beverly L. Herter  |  |   |  | 22. Name and Address of Facility<br>Rapp Funeral & Cremation Services<br>933 Gist Avenue Silver Spring, MD  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Aspiration Pneumonia<br>Due to (or as a consequence of):<br>b. Lung Cancer<br>Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) Assisted Living |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>MM   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>Merlyn K. Vemury M.D.  |  |   |  | 29c. License number<br>D35791   |  | 29d. Date signed (Month, Day, Year)<br>September 07, 2000                                       |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Merlyn K. Vemury M.D. 9801 Georgia Ave Suite 227, Silver Spring, MD 20902   |  |   |  |   |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>SEP 11 2000  |  |   |  | 32. Registrar's Signature<br>B. Sparks  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

00 30341

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MAURICE HINSHAW</b>                                      |   | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>7</b> Year <b>2000</b>   |  | 3. Time of Death<br><b>3:50 PM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>346 14 6235</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth<br>Month <b>MAY</b> Day <b>15</b> Year <b>1920</b>                                     |   | 9. Birthplace (State or Foreign Country)<br><b>ILLINOIS</b>  |  |  |
| Usual Residence of Decedent   |   |   |  |  |  |
| 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>GAITHERSBURG</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |  |  |
| 10e. Street and Number<br><b>103 ROLLING ROAD</b>   |   |   | 10f. Zip Code<br><b>20877</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                                |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PRINTER</b>                            |  | 16b. Kind of Business/Industry<br><b>U.S. PRINTING OFFICE</b>                        |
| 17. Father's Name (First, Middle, Last)<br><b>DON A. HINSHAW</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ESTHER IRENE JOHNSON</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>RICHARD COOPER, NEPHEW</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18913 MARSH HAWK LANE, GAITHERSBURG, MD. 20879</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NORBECK MEMORIAL PARK</b>  |  | Date<br><b>9/11/00</b>   | 20c. Location - City or Town, State<br><b>OLNEY, MD.</b>                             |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>MURIEL H. BARBER FUNERAL HOME</b><br><b>P.O. BOX 5038, LAYTONSVILLE, MD. 20882</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |   | s. <b>METASTATIC PROSTATE CANCER</b>  |  |  |  |
| Due to (or as a consequence of):  |   |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   | b. Due to (or as a consequence of):   |  |  |  |
|   |   | c. Due to (or as a consequence of):   |  |  |  |
|   |   | d. Due to (or as a consequence of):   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No            |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D53317</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/7/2000</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH A. BALL 16220 FREDERICK ROAD SUITE 213 GAITHERSBURG MD 20877</b>  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 11 2000</b>   |   | 32. Registrar's Signature<br>   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30342

|   |  |   |   |   |   |  |  |  |   |  |  |
|---|--|---|---|---|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BEVERLY MARY HERBST</b>                       |   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>SEPT 11, 2000</b> |  | 3. Time of Death<br><b>6:50 PM</b>   |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CASEY HOUSE HOSPICE</b> |   |   |   |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577.24.6464</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>NOV 29, 1924</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b>   |  |  |
|   | Usual Residence of Decedent  |   |   |   |   |  |  |  |   |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>MONTGOMERY</b>  |   | 10c. City, Town or Location<br><b>SILVER SPRING</b> |   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><b>11004 NICHALAS DRIVE</b>   |  |   |   |   | 10f. Zip Code<br><b>20902</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>CO-OWNER</b>  |  |  | 16b. Kind of Business/Industry<br><b>DECATUR LIQ. STORE</b>                                    |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MEYER GOLDSTEIN</b>   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARAH BROWN</b>   |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JACK HERBST / HUSBAND</b>  |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11004 NICHOLAS DR, SILVER SPRING, MARYLAND 20902</b>  |  |  |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GARDENS</b>  |  | 20c. Location - City or Town, State<br><b>OLNEY, MARYLAND</b>  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |   |   | 22. Name and Address of Facility<br><b>EDWARD SAGEL FUNERAL DIRECTION, INC.<br/>1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>  |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC BREAST CARCINOMA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |   |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>4 YEARS</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |  |
|   |  |   |   |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |   |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  |   |   |   | 29c. License number<br><b>D37620</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPT 12, 2000</b>  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. MARK GODEC, 6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND 20850</b>  |  |   |   |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>   |  | 32. Registrar's Signature<br> |   |   |   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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Najem Hammadi

State of Maryland / Department of Health and Mental Hygiene

Amend item 23a, pt II, 27 per me G788 10/19/00 yf  
Amend #8, 9/12/2000. JW, Montg. Co.

## Certificate of Death

Reg. No.

00 30343

|  |  |                               |   |  |   |  |   |   |  |  |
|--|--|-------------------------------|---|--|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>NAJEM HAMMADI</b>   |                               |   |  | 2. Date of Death<br>Month Day Year<br><b>September 08, 2000</b>   |  |   |   | 3. Time of Death<br><b>7:38 A.M.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Doctors Community Hospital</b>  |                               |   |  | 4b. City, Town, or Location of Death<br><b>Lanham</b>   |  |   |   | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>225-87-1374</b>  |                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>7-1-49 July 1 1949</b>                            |   | 9. Birthplace (State or Foreign Country)<br><b>IRAQ</b>  |  |
|  | Usual Residence of Decedent  |                               |   |  |   |  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |                               | 10b. County<br><b>Prince George</b>   |  | 10c. City, Town or Location<br><b>New Carrollton</b>  |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  | 10e. Street and Number<br><b>7729 Riverdale Rd.</b>  |                               |   |  | 10f. Zip Code<br><b>20784</b>   |  | 10g. Citizen of What Country?<br><b>Iraq</b>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Iraqi</b> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)   |                               |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mattress Repair</b>   |  |   | 16b. Kind of Business/Industry<br><b>Mattress</b>                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>About Najem - Son</b>  |                               |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sabria Saleh</b>  |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ali Hammadi</b>   |                               |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7729 Riverdale Rd, New Carrollton, Md. 20784</b>  |  |   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                               |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>George Wash. Cemetery</b>  |  | Date<br><b>9-11-2000</b>  |   | 20c. Location - City or Town, State<br><b>Adelphi, Maryland</b>                                |  |
|  | 21. Signature of Funeral Service Licensee<br>  |                               |   |  | 22. Name and Address of Facility<br><b>Universal II Mortuary Inc.<br/>411 Kennedy St, N.W., Washington, D.C.</b>  |  |   |   |  |  |
|  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><br><b>c. _____</b><br>Due to (or as a consequence of):<br><br><b>d. _____</b> |                               |   |  |   |  |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>UPPER GASTRO-INTESTINAL HEMORRHAGE</b>  |                               |   |  |   |  |   |   |  |  |
| State Registrar  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                               |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |                               | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                               |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |                               |   |  |   |  |   |   |  |  |
|  | 29b. Signature and title of certifier<br>  |                               |   |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>September 09, 2000</b>                            |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b> |  |                               |   |  |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |  | 32. Registrar's Signature<br> |   |  |   |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30344

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDNA MAE HALL

2. Date of Death

Month Day Year  
SEPTEMBER 8, 2000

3. Time of Death

10:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

RANDOLPH HILLS NURSING HOME

4b. City, Town, or Location of Death

WHEATON

4c. County of Death

MONTGOMERY

5. Social Security Number

283-28-4767

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 5, 1930

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

304 Bradley Avenue

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1950-

If Yes, Give

Year or Dates: 1952

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Marvin Farmer

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Day

19a. Informant's Name/Relationship (Type, Print)

Margaret Hall, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5932 Lemay Road, Rockville, MD 20851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

Sept 11,

2000

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 E. Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. BRAIN CANCER

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 YEAR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08944

29d. Date signed (Month, Day, Year)

SEPTEMBER 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN C. SHARGEL, M.D., 3720 FARRAGUT AVENUE, KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Alfred Smith

B.K.S

ROBERT W. HUMPHREY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30345

## Certificate of Death

Reg. No.

|  |  |   |   |  |   |   |   |  |  |  |  |
|--|--|---|---|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Wilson Humphrey</b>                    |   |   |  | 2. Date of Death<br>Month <b>SEPT.</b> Day <b>17,</b> Year <b>2000</b>  |   |   |  | 3. Time of Death<br><b>12:30 PM</b>  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   |   |  | 4c. County of Death<br><b>---</b>  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-36-9184</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 10, 1937</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                    |  |  |
|  | Usual Residence of Decedent  |   |   |  |   |   |   |  |  |  |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>                     |   | 10c. City, Town or Location<br><b>Parkton</b>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>20428 Downes Road</b>   |  |   |   | 10f. Zip Code<br><b>21120</b>  |   |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1957-1961</b>  |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>---</b> |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>---</b>  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b> |   |   |   | 16b. Kind of Business/Industry<br><b>Merchandise Distribution</b>                              |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Wilson Humphrey</b>   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen L. Simpson</b>  |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Cindy L. Humphrey/Wife</b>  |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20428 Downes Rd., Parkton, MD 21120</b> |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>---</b>   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Stablers United Methodist Cemetery</b>   |  |   | Date<br><b>Sept. 22, 2000</b>   |   | 20c. Location - City or Town, State<br><b>Parkton, MD</b>                                      |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>J.J. Hartenstein</b>   |  |   | 22. Name and Address of Facility<br><b>J.J. Hartenstein Mortuary, Inc.<br/>24 Second St., New Freedom, PA 17349</b>   |  |   |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Injuries</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |   |   |   |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>---</b> |  |   |   |   |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   | 28a. Date of Injury (Month, Day, Year)<br><b>9/17/00</b>  |  | 28b. Time of Injury<br><b>0921 M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>Pedestrian struck by Motor Vehicle</b> |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Street</b>  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Interstate 83<br/>Baltimore, Md</b>  |  |   |   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |   |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>J. Restaner, M.D.</b>  |  |   |   |  | 29c. License number<br><b>O.C.M.E</b>   |   |   | 29d. Date signed (Month, Day, Year)<br><b>SEPT. 18, 2000</b>                                   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Restaner 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |   |   |   |  |  |  |  |
| State Registrar<br><b>SEP 25 2000</b>  |  | 32. Registrar's Signature<br><b>Benjamin Sparks</b> |   |  |   |   |   |  |  |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 3 per phys. G787 9/25/00 yf

## Certificate of Death

Reg. No.

00 30346

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Samuel Howse

2. Date of Death

Month Day Year  
September 2, 20003. Time of Death  
unknown

4a. Facility Name (If not Institution, give street and number)

(None) 5476 A-3 Cedar Lane

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

228-54-9049

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 04, 1940

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5476 Cedar Lane

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Safeway Stores

17. Father's Name (First, Middle, Last)

William Henry Howse

18. Mother's Name (First, Middle, Maiden Surname)

Sara Walker

19a. Informant's Name/Relationship (Type, Print)

Virginia Barlow/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2212 Point of Rock Road, Chester, VA 23836

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Grace Methodist Ch. Cem. 9-7-00

Date

20c. Location - City or Town, State

Wilson, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service

5517 Vine Street Alexandria, VA 22310

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial Infarction  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ventricular Gitters

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

022587

29d. Date signed (Month, Day, Year)

September 15, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gary Potts 11055 Grille Potomac Columbia, Maryland, 21084

State

Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

Beverly B Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





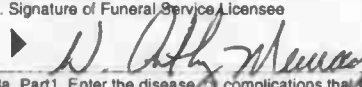
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30347

Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |   |   |  |
|---|---|---|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Thelma Ivey</b>  |   |  |   | 2. Date of Death<br>Month <b>Sep.</b> Day <b>8,</b> Year <b>2000</b> |  | 3. Time of Death<br><b>11:30 PM.</b>                        |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care Bethesda Nursing Home</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>              |  | 4c. County of Death<br><b>Montgomery</b>                    |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-44-4531</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 11, 1902</b> |   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Florida</b>  |   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>                                     |  | 10c. City, Town or Location<br><b>Bethesda</b>              |   |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6530 Democracy Blvd</b>  |  | 10f. Zip Code<br><b>20817</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>I</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrative Assistant</b>  |  | 16b. Kind of Business/Industry<br><b>U.S. State Dept.</b>   |  |  |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Rete Fletcher</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alva Margaret Sears</b>   |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert Ivey - Son</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6 Partridge Lane, Darien, Connecticut 06820</b>   |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Whidden-McLean F.H.</b>  |  | Date<br><b>9/15/2000</b>  |  | 20c. Location - City or Town, State<br><b>Bartow, Fl.</b>  |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisc. Ave. NW., Washington, D.C. 20016</b>   |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cerebral Vascular Accident</b><br>Due to (or as a consequence of):<br><b>b. Atrial Fibrillation</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |   | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|   |   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |  |
|   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>M51280</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Sept. 11, 2000</b>   |   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Anushiravan Dadgar, MD. 13219 Executive Park Terr., Germantown, Md. 20874</b>  |   |   |  |   |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |   | 32. Registrar's Signature<br>   |  |   |  |  |   |   |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

AT EIGHTH

71

X

X

X

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30348

|  |   |   |  |  |  |   |  |  |  |
|--|---|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Walter James Imes                       |   |  |  | 2. Date of Death<br>Month Day Year<br>September 12, 2000 |   | 3. Time of Death<br>12:40 P.M.                       |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>220 Baltimore St. |   |  |  | 4b. City, Town, or Location of Death<br>Cumberland       |   | 4c. County of Death<br>Allegany                      |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>219-34-6321  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>61 Yrs.                |   | 8. Date of Birth (Month, Day, Year)<br>March 5, 1939 |  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland                                |   | 10a. State<br>MD   |  | 10b. County<br>Allegany                                  |   | 10c. City, Town or Location<br>Cumberland            |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br>220 Baltimore St.  |  | 10f. Zip Code<br>21502  |  | 10g. Citizen of What Country?<br>United States   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                            |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Security Guard   |  | 16b. Kind of Business/Industry<br>Security   |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Walter Clay Imes  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Temperance (Pettit)   |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Kathleen Hose / sister   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 73 Oldtown, MD 21555   |  |   |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cumberland Crematory  |  | Date<br>9/13/2000  |  | 20c. Location - City or Town, State<br>Cumberland, MD                                       |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Robert C. Adams, Jr.</i>   |   |   |  | 22. Name and Address of Facility<br>Merritt-Adams Funeral Home, P.A. 404 Decatur St.<br>Cumberland, MD 21502   |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. Hypertensive Cardiovascular Heart Disease<br>Due to (or as a consequence of):  |   |   |  |  |  |   |  | Unknown Years  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):  |   |   |  |  |  |   |  |  |  |
| c. Due to (or as a consequence of):  |   |   |  |  |  |   |  |  |  |
| d. Due to (or as a consequence of):  |   |   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |   |   |  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>Paul Snow</i>  |   |   |  | 29c. License number<br>D 09159   |  | 29d. Date signed (Month, Day, Year)<br>September 12, 2000                                   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Paul Snow, M.D. Deputy Medical Examiner 124 W. 3rd St. Cumberland, Md. 21502   |   |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 14 2000   |   |   |  | 32. Registrar's Signature<br><i>Benjamin B. Sparks</i>   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30349

|   |  |   |   |  |   |   |  |  |   |   |   |
|---|--|---|---|--|---|---|--|--|---|---|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Wilbur Lee Junes</b>  |   | 2. Date of Death<br>Month <b>September</b> Day <b>8</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>12:30 PM</b>                   |   |  |  |   |   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4521 East-West Highway #201</b>   |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b>              |   |  |  |   |   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-52-8102</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.  | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>   | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>      |   |  |  |   |   |   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>April 22, 1938</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>   |  |   |   |  |  |   |   |   |
| Usual Residence of Decedent   |  |   |   |  |   |   |  |  |   |   |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Bethesda</b>   |   |   |  |  |   |   |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |   |  |  |   |   |   |
| 10e. Street and Number<br><b>4521 East West Highway #201</b>  |  |   | 10f. Zip Code<br><b>20814</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |   |  |  |   |   |   |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   |  |  |   |   |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |  |   |   |  |  |   |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>House Painter</b>   |   | 16b. Kind of Business/Industry<br><b>Painting</b>  |   |   |  |  |   |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Guy Wilbur Junes</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Lee Hill</b>   |  |   |   |  |  |   |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Ann Koutsos/Sister</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2400 Harvey Gummel Rd., Hampstead, Maryland 21074</b> |  |   |   |  |  |   |   |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Highland Burial Park</b>   |   | 20c. Location - City or Town, State<br><b>Danville, Virginia</b>   |   |   |  |  |   |   |   |
| 21. Signature of Funeral Service Licensee<br><br><b>M00198</b>  |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.</b><br><b>7557 Wisconsin Avenue</b><br><b>Bethesda, Maryland 20814-3501</b>   |   |  |   |   |  |  |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |  |   |   |  |  |   |   |   |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Arteriosclerotic Cardiovascular Disease</b></td> <td rowspan="4">           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):<br/><br/>           Due to (or as a consequence of):         </td> </tr> <tr> <td>b. <b>Hypertension</b></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> |  |   |   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>Arteriosclerotic Cardiovascular Disease</b>  | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): | b. <b>Hypertension</b>  | c.  | d.  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. <b>Arteriosclerotic Cardiovascular Disease</b>  | Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):  |   |  |   |   |  |  |   |   |   |
|   | b. <b>Hypertension</b>   |   |   |  |   |   |  |  |   |   |   |
|   | c.   |   |   |  |   |   |  |  |   |   |   |
|   | d.   |   |   |  |   |   |  |  |   |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   |   |  |  |   |   |   |
| <table border="1"> <tr> <td><b>Tobacco Addiction</b></td> <td>23b. Did tobacco use contribute to the cause of death?<br/><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td><b>Psoriasis</b></td> <td>24a. Was an autopsy performed?<br/><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td><b>Left Lower Leg (above knee) Amputation</b></td> <td>24b. Were autopsy findings available prior to completion of cause of death?<br/><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>  |  |   |   |  |   | <b>Tobacco Addiction</b>  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown | <b>Psoriasis</b>   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <b>Left Lower Leg (above knee) Amputation</b> | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| <b>Tobacco Addiction</b>  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |   |   |  |  |   |   |   |
| <b>Psoriasis</b>  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |   |  |  |   |   |   |
| <b>Left Lower Leg (above knee) Amputation</b>   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |   |   |  |  |   |   |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |   |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   |   |  |  |   |   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |   |   |  |  |   |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |   |  |  |   |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |   |   |  |  |   |   |   |
| 29b. Signature and title of certifier<br><br><b>Louise Stomierowski, M.D.</b>  |  | 29c. License number<br><b>D23788</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>September 8, 2000</b>  |   |   |  |  |   |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Louise Stomierowski, M.D. 6111 Executive Blvd., Rockville, Maryland 20852</b>  |  |   |   |  |   |   |  |  |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>   |  | 32. Registrar's Signature<br>   |   |  |   |   |  |  |   |   |   |





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State of Maryland / Department of Health and Mental Hygiene

00 30350

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dolores M. Jones

2. Date of Death

September 11, 2000

3. Time of Death

11:26 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

579-54-0385

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 15, 1935

9. Birthplace (State or Foreign Country)

El Salvador

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5700 Foggy Lane

10f. Zip Code

20855

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

2 ☒ Yes 2 ☐ No Specify:  
El Salvadorian

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Fernando Moisa

18. Mother's Name (First, Middle, Maiden Surname)

Josefina Palomo

19a. Informant's Name/Relationship (Type, Print)

Robert E. Jones/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5700 Foggy Lane, Rockville, MD 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 9/14/00

Date

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

► *Steen D Strand*

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cor Pulmonale

Due to (or as a consequence of):

2 months

b. Valvular Heart Disease

Due to (or as a consequence of):

1 year

c. Metastatic Carcinoid

Due to (or as a consequence of):

less than 7 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatic Failure two degrees carcinoid

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *Linda M Burrell MD*

29c. License number

D 35996

29d. Date signed (Month, Day, Year)

September 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Burrell, MD 2730 University Blvd., #400, Silver Spring, MD

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

► *James B. Sparks*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



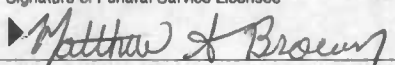
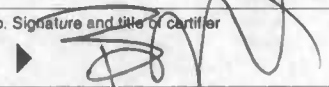

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State of Maryland / Department of Health and Mental Hygiene

00 30351

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Khatija S. Jama1</b>                        |   | 2. Date of Death<br>Month Day Year<br><b>September 5, 2000</b>  |  | 3. Time of Death<br><b>4:50P.</b>        |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Suburban Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-04-0508</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.           |
|   | 8. Date of Birth (Month, Day, Year)<br><b>March 31, 1922</b>                               |   | 9. Birthplace (State or Foreign Country)<br><b>Pakistan</b>   |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Rockville</b>  |  |
| 10e. Street and Number<br><b>4601 Coachway Drive</b>  |  | 10f. Zip Code<br><b>20852</b>   |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |   | 16b. Kind of Business/Industry<br><b>own home</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Mirza Mehdi Shooshtari</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Razia Begum Shirazee</b>                                    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Shireen Zarei (daughter)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland National Mem. Park 9/7/00 Laurel, Maryland</b>  |   | 20c. Location - City or Town, State  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardio Pulmonary Arrest</b><br>Due to (or as a consequence of):<br><b>b. Cancer of Gall Bladder, possible metastasis</b><br>Due to (or as a consequence of):<br><b>c. Arrhythmia</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cancer</b>   |  |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |  |
| 29b. Signature and Title of Certifier<br>  |  | 29c. License number<br><b>D54776</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>09/05/2000</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Barton W. Leonard, MD 8600 Old Georgetown Rd. Bethesda, Maryland 20814</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 11 2000</b>   |  | 32. Registrar's Signature<br>   |   |  |  |

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State of Maryland / Department of Health and Mental Hygiene

00 30352

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROSALYN C. KRASNOW

2. Date of Death

Month Day Year  
SEPT 10, 2000

3. Time of Death

3:20 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3330 NORTH LEISURE WORLD BLVD. #531

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

057.16.5569

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 15, 1920

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3330 NORTH LEISURE WORLD BLVD. #531

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

CHARLES HOFFMAN

18. Mother's Name (First, Middle, Maiden Surname)

ADELE BLITZER

19a. Informant's Name/Relationship (Type, Print)

STEVEN KRASNOW/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 DONMILLS COURT, ROCKVILLE, MARYLAND 20850

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHARON GARDENS CEMETERY

Date

SEP 12,

2000

20c. Location - City or Town, State

VALHALLA, NEW YORK

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

HEPATOMA OF LIVER

1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. HEPATITIS C DISEASE

YEARS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D08381

29d. Date signed (Month, Day, Year)

SEPTEMBER 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BENJAMIN AVRUNIN, MD, PA, 18111 PRINCE PHILIP DRIVE, SUITE 209, OLNEY, MD 20832

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

Denise G. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20





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State of Maryland / Department of Health and Mental Hygiene 00 30353

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |  |   |  |
|---|--|--|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ESTHER E. KOHN</b>  |  |   |   | 2. Date of Death<br>Month Day Year<br><b>SEPT. 11, 2000</b>  |  | 3. Time of Death<br><b>4:30 AM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>INDEPENDENCE COURT NURSING HOME</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>HYATTSVILLE</b>   |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                            |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>289-44-2950</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 11, 1908</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>INDIANA</b>   |  | 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>PRINCE GEORGES</b>   |  | 10c. City, Town or Location<br><b>HYATTSVILLE</b>                       |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |   | 10e. Street and Number<br><b>5821 QUEENS CHAPEL RD.</b>  |  |   |  |
|   | 10f. Zip Code<br><b>20782</b>  |  |   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SCHOOL TEACHER</b>                    |   | 16b. Kind of Business/Industry<br><b>PUBLIC SCHOOLS</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>CLAYTON L. BARTHOLOMEW</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MAUDE ELNORA MISHLER</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>NANCY JARVIS/DAUGHTER</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4305 SHERIDAN ST., UNIVERSITY PARK, MD. 20782</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>   |   | 20c. Location - City or Town, State<br><b>9/13/00 RIVERDALE, MD.</b>   |  | 20d. Date   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease 441A</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |   |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA ALZHEIMER'S TYPE</b>  |  |   |   |  |  |   |  |
| 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year) |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                            |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |  |   | 29c. License number<br><b>D01852</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPT 11 2000</b>                           |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL DeVORE, M.D. 4203 QUEENSBURY RD., HYATTSVILLE, MD.</b>  |  |  |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |  |  |   | 32. Registrar's Signature<br> |  |  |   |  |

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State of Maryland / Department of Health and Mental Hygiene

00 30354

## Certificate of Death

Reg. No.

|   |  |                           |   |   |   |  |  |  |  |  |  |
|---|--|---------------------------|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Jessie Caroline Knorr                          |                           |   |   | 2. Date of Death<br>Month Day Year<br>September 4, 2000 |  |  |  | 3. Time of Death<br>9:00 PM                                      |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Wintergrove Nursing Home |                           |   |   | 4b. City, Town, or Location of Death<br>Olney           |  |  |  | 4c. County of Death<br>Montgomery                                |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>578-30-2388   |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>89 Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br>Sep. 20, 1910 |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania         |  |  |
|   | Usual Residence of Decedent  |                           |   |   |   |  |  |  |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>Montgomery |   | 10c. City, Town or Location<br>Olney  |   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br>18110 Prince Phillip Drive  |  |                           |   | 10f. Zip Code<br>20832  |   |  |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 4  |  |                           |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Registered Nurse   |   |  |  | 16b. Kind of Business/Industry<br>Health Care  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Samuel Kildoo  |  |                           |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Venetta Moore   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>James P. Knorr / Son  |  |                           |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4 Jaystone Court, Silver Spring, Maryland 20906   |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery   |   |  |  | 20c. Location - City or Town, State<br>09/08/00 Brentwood, Maryland  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                           |   | 22. Name and Address of Facility<br>Hines-Rinaldi Funeral Home<br>11800 New Hampshire Avenue<br>Silver Spring, Maryland 20904   |   |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                           |   |   |   |  |  |  |  | Approximate Interval Between Onset and Death |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Myocardial Infarction<br>Due to (or as a consequence of):   |  |                           |   |   |   |  |  |  |  | Immediate                                    |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):   |  |                           |   |   |   |  |  |  |  |  |  |
| c. Due to (or as a consequence of):   |  |                           |   |   |   |  |  |  |  |  |  |
| d. Due to (or as a consequence of):   |  |                           |   |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Multi-infarct dementia  |  |                           |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   |  |                           |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |
|   |  |                           |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                           |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |                           |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred            |  |
|   |  |                           |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                           |   |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |  |                           |   | 29c. License number<br>D35045   |   |  |  | 29d. Date signed (Month, Day, Year)<br>September 5, 2000   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Philip Henjum, M.D. 3416 Olanwood Court, Olney, Maryland 20832  |  |                           |   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 11 2000  |  |                           |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner




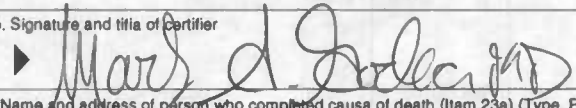
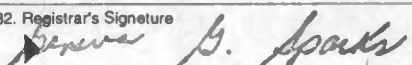
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30355

## Certificate of Death

Reg. No.

|   |   |  |   |                                |  |
|---|---|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Hylda Kamisar</b>  |  | 2. Date of Death<br>Month <b>Sept.</b> Day <b>11</b> Year <b>2000</b>   |                                | 3. Time of Death<br><b>4:00 a.m.</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Casey House</b>  |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>  |                                | 4c. County of Death<br><b>Montgomery</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>282-26-8023</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>72 Yrs.</b>  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 2, 1927</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |                                |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |                                |  |
|   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Chevy Chase</b>   |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>4450 South Park Avenue</b>   |  | 10f. Zip Code<br><b>20815</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:         |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>5+ 2</b>                   |                                |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Librarian</b>   |  | 16b. Kind of Business/Industry<br><b>Library of Congress</b>  |                                |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Samuel Kamisar</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Zelda Leibovitz</b>   |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bernice Frank (sister)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1160 Bower Hill Road, #708B Pittsburgh, Pa. 15243</b> |                                |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 9/12/2000</b>   |                                | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>                     |                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Multiple Myeloma</b><br>Dua to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>3 1/2 years</b><br><br>Dua to (or as a consequence of):<br><br>Dua to (or as a consequence of):<br><br>Dua to (or as a consequence of): |   |  |   |                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |                                |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>  |   |  |   |                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   |  |   |                                |  |
| 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury</b><br><b>28c. Injury et Work?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>28d. Describe how injury occurred</b><br><b>28e. Location (Street and Number or Rural Route Number, City or Town, State)</b>  |   |  |   |                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |  |   |                                |  |
| 29b. Signature and title of certifier<br>  |   |  |   |                                |  |
| 29c. License number<br><b>D37620</b>  |   |  |   |                                |  |
| 29d. Date signed (Month, Day, Year)<br><b>September 11, 2000</b>  |   |  |   |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mark Godec, M.D. 6001 Muncaster Mill Rd. Rockville, Maryland 20885</b>   |   |  |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |   |  |   |                                |  |
| 32. Registrar's Signature<br>   |   |  |   |                                |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30356

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>LENA K. KAISER   |  |   |  | 2. Date of Death<br>Month Day Year<br>SEP 13, 2000   |  | 3. Time of Death<br>11:45 AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>HOLY CROSS HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>SILVER SPRING  |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>578-20-4853   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>79 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>MAY 28, 1921                                  |  |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  | 10a. State<br>MD  |  | 10b. County<br>MONTGOMERY  |  | 10c. City, Town or Location<br>SILVER SPRING   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>11108 EASECREST DRIVE   |  | 10f. Zip Code<br>20902   |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |  | 16b. Kind of Business/Industry<br>OWN HOME   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>MAX KANS  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY SOBIN  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>CHARLES KAISER/SON   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2505 COACH HOUSE WAY #2C, FREDERICK, MD 21702   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MT. LEBANON CEMETERY  |  | 20c. Date<br>SEP 15, 2000  |  | 20d. Location - City or Town, State<br>ADELPHI, MARYLAND                             |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>EDWARD SAGEL FUNERAL DIRECTION, INC.<br>1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. RESPIRATORY FAILURE<br>Due to (or as a consequence of):<br>b. PULMONARY EMBOLISM<br>Due to (or as a consequence of):<br>c. PRESUMED ISCHEMIC CARDIOMYOPATHY<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>1 DAY<br>1 DAY<br>HRS  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HYPERTENSION, THROMBOCYTOSIS, CHRONIC VENOUS INSUFFICIENCY   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D36252  |  | 29d. Date signed (Month, Day, Year)<br>SEP 13, 2000                                  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>STEVEN T. KARIYA MD 11501 GEORGIA AVE #515 WILMINGTON MD 20902   |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>SEP 15 2000   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

00 30357

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |  |
|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN PAUL KASTRONIS, SR.</b>                 |   |  | 2. Date of Death<br>Month <b>September</b> Day <b>13</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>0345</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4404 Accokeek Road</b> |   |  | 4b. City, Town, or Location of Death<br><b>Brandywine</b>  |  | 4c. County of Death<br><b>Prince George's</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>170-30-7000</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                   | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 10, 1938</b>                                    |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                             |   |  |  |  |  |
| Usual Residence of Decedent   |   |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Brandywine</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 10e. Street and Number<br><b>4404 Accokeek Road</b>   |   |   | 10f. Zip Code<br><b>20613</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Brick Mason</b>                        |  | 16b. Kind of Business/Industry<br><b>Self-Employed</b>           |  |
| 17. Father's Name (First, Middle, Last)<br><b>Steve Kastronis</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Johanna Mazore</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Louemma Kastronis/Wife</b>   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4404 Accokeek Road, Brandywine, Maryland 20613</b> |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>The Hunt Crematory</b>   |  | Data<br><b>09-15-2000</b>  |  | 20c. Location - City or Town, State<br><b>Waldorf, Maryland</b>                                |
| 21. Signature of Funeral Service Director<br><b>JOHN P. KNISLEY MD1164</b>  |   | 22. Name and Address of Facility<br><b>The Hunt Funeral Home, Inc.<br/>P.O. Box 156, Waldorf, Maryland 20604</b>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. Self-inflicted Gunshot Wound to Head</b>   |   |   |  |  |  |  |
| Due to (or as a consequence of):  |   |   |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b>  |   |   |  |  |  |  |
| <b>c. Due to (or as a consequence of):</b>  |   |   |  |  |  |  |
| <b>d. Due to (or as a consequence of):</b>  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cancer of Neck</b>   |   |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>September 13, 2000</b>   |  | 28b. Time of Injury<br><b>3:45 AM</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |
| 28d. Describe how injury occurred<br><b>Patient shot himself in mouth - exit wound posterior skull</b>  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>4404 Accokeek Road Brandywine, Maryland 20613</b>  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Salvador Sylvestre, DO</b>  |   |   | 29c. License number<br><b>H0055927</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 13, 2000</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Salvador Sylvestre, 3001 Hospital Drive, Cheverly, Maryland 20785</b>  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 15 2000</b>   |   | 32. Registrar's Signature<br><b>Benita B. Sparks</b>  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30358

## Certificate of Death

Reg. No.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Gail Kelly</b>   |   | 2. Date of Death<br>Month <b>September</b> Day <b>10</b> Year <b>2000</b> |  | 3. Time of Death<br><b>12:30 P.M.</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1405 B, Key Parkway East, Apt. 203</b> |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>                  |  | 4c. County of Death<br><b>Frederick</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>235-12-1266</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                          | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.          |
|   | 8. Date of Birth (Month, Day, Year)<br><b>May 1, 1920</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>               |  |   |
| Usual Residence of Decedent   |   |   |   |  |   |
| 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Frederick</b>   |   | 10c. City, Town or Location<br><b>Frederick</b>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |   |  |   |
| 10e. Street and Number<br><b>1405B, Key Parkway East, Apt 203</b>   |   | 10f. Zip Code<br><b>21702</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teller</b>  |   | 16b. Kind of Business/Industry<br><b>Bank</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Frederick Allen Ravenscroft</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Loma Christine Musser</b>   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph F. Gideon - Son</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9004 Mountainberry Circle, Frederick, MD 21702</b>  |   |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>   |   | 20c. Location - City or Town, State<br><b>9/12/00 Hagerstown, MD</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Barbara A. Williams</b>   |   | 22. Name and Address of Facility<br><b>John T. Williams Funeral Home - Brunswick, MD 21716</b>  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br><br>Due to (or as a consequence of):<br><b>b. ISCHEMIC HEART DISEASE</b><br><br>Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><b>6 mos</b><br><br><b>YEARS</b>  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC RENAL FAILURE</b>  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |   |  |   |
| 29b. Signature and title of certifier<br><b>W. Williams MD</b>  |   | 29c. License number<br><b>D16675</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>9/12/00</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>WAYNE ALGIER, BRUNSWICK, MD 21716</b>  |   |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |   |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30359

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irwin Stuart Leibenhaut

2. Date of Death

Month Sept Day 8th Year 2000

3. Time of Death

1:00 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Hebrew Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

081-03-9547

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) Sept. 19, 1914

9. Birthplace (State or Foreign Country)

New York, N.Y.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8100 Connecticut Avenue, #1022

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Pharmacist

16b. Kind of Business/Industry

private

17. Father's Name (First, Middle, Last)

Samuel

Leibenhaut

18. Mother's Name (First, Middle, Maiden Surname)

Minnie

Bierman

19a. Informant's Name/Relationship (Type, Print)

Ruth S. Leibenhaut (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

New Mt. Zion Cemetery 9/10/2000

Date

20c. Location - City or Town, State

Lyndhurst, New Jersey

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Rd. Beltsville, Maryland 20705

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. acute cardio-pulmonary arrest  
Due to (or as a consequence of):b. Coronary artery disease  
Due to (or as a consequence of):Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

congestion heart failure

Hypothyroidism

chronic

cerebral ischemic

Seizure

Constipation

depression

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Consuela Alvarez

29c. License number

D-44907

29d. Date signed (Month, Day, Year)

Sept 8th 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 Montrose Road Rockville, MD 20852

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30360

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WANG Y. LEE

2. Date of Death

Month Day Year  
Sept. 10, 2000

3. Time of Death

3:15pm

4a. Facility Name (If not Institution, give street and number)

Shady Grove Adventist Nursing &amp; Rehab.

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

218-19-9058

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

105

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 1, 1895

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17313 Founders Mill Drive

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

Asian

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Summa)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

Doris T. Yee (Granddaughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17313 Founders Mill Drive, Rockville, MD 20855

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

9/19/00

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 MONTH

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. URINARY BLADDER CANCER

Due to (or as a consequence of):

1 MONTH

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide26a. Date of Injury  
(Month, Day Year)26b. Time of  
Injury26c. Injury at  
Work?1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)26f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

MD

29c. License number

D28656

29d. Date signed (Month, Day, Year)

SEPTEMBER 11, 2000

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)

RAVI PASSI, M.D. 8609 SECOND AVENUE #404B SILVER SPRING, MARYLAND 20910

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30361

Certificate of Death

Reg. No.

|   |   |  |  |   |  |
|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Laspada</b>                                   |  | 2. Date of Death<br>Month <b>Sep.</b> Day <b>9,</b> Year <b>2000</b> |   | 3. Time of Death<br><b>11:00 AM.</b>     |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7401 Persimmon Tree Road</b> |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>              |   | 4c. County of Death<br><b>Montgomery</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>228-20-6574</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                     | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.           |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Jun. 29, 1927</b>                                       |  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>          |   |  |
| Usual Residence of Decedent   |   |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Bethesda</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |   |  |
| 10e. Street and Number<br><b>7401 Persimmon Tree Road</b>   |   | 10f. Zip Code<br><b>20817</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Registered Nurse</b>                 |  | 16b. Kind of Business/Industry<br><b>Nursing</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Asa Dickerson Watkins</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Hatton Stegar</b>   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary laSpada - Daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1530 N. Key Blvd. #301, Arlington, Va. 22209</b> |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem. 9/18/2000</b>                                   |  | 20c. Location - City or Town, State<br><b>Arlington, Va.</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Thomas E. Honnabaker</b>  |   | 22. Name and Address of Facility<br><b>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016</b>                                    |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |  |   |  |
| Immediate Cause (Final disease or condition resulting in death)   |   |  |  |   |  |
| a. <b>Metastatic Non-Small Cell Lung Cancer</b> 5 Weeks   |   |  |  |   |  |
| Due to (or as a consequence of):  |   |  |  |   |  |
| b. Due to (or as a consequence of):   |   |  |  |   |  |
| c. Due to (or as a consequence of):   |   |  |  |   |  |
| d. Due to (or as a consequence of):   |   |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  |
|   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>James C. Brown, MD</b>  |   | 29c. License number<br><b>D07285</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 12, 2000</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James A. Brown, MD. 10605 Concord St. #300, Kensington, Md. 20895-2594</b>   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>   |   | 32. Registrar's Signature<br><b>Beverly B. Sparks</b>  |  |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30362

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GLORIA JANET LOWERY</b>   |  |   |  | 2. Date of Death<br>Month <b>SEPT</b> Day <b>11</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>7:32 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>  |  | 4c. County of Death<br><b>Frederick</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>213-40-5793</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>March 22, 1943</b>                                |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>9013 Bethel Road</b>  |  |   |  | 10f. Zip Code<br><b>21702</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>College</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Machine Shop</b>  |  | 16b. Kind of Business/Industry<br><b>Silk Screening</b>                                     |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Francis Leon Lowery Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Myrtle Virginia Grimes</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jane E. Wonders/ Sister</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>726 S. Baltimore Street, Dillsburg, Pa. 17019</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Darnestown Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>9/13/2000 Darnestown, Maryland</b>  |  | 20d. Date   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Jodel D. Wynn</i>  |  |   |  | 22. Name and Address of Facility<br><b>Olin L. Molesworth P. A. Funeral Home</b><br><b>26401 Ridge Road, Damascus, Maryland 20872</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Non-small cell Lung Cancer</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><b>18 mo.</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
|   |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><i>George I. Smith, M.D. VMA</i>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D10587</b>   |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>9/13/2000</b>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GEORGE I. SMITH, M.D. VICE-PRES. MED. AFFAIRS</b>   |  |   |  | <b>FREDERICK MEM. HOSP. FREDERICK, MD. 21701</b>  |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>  |  |   |  | 32. Registrar's Signature<br><i>B. Spaul</i>  |  |   |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 30363

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>Ethel Marie Lantz</b>   |  |   |  | 2. Date of Death<br>Month <b>September</b> Day <b>10</b> , Year <b>2000</b>  |  |   |  | 3. Time of Death<br><b>2:05 AM</b>                                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Health Care Center</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |  |   |  | 4c. County of Death<br><b>Frederick</b>                                 |  |
| Funeral<br>Director                              | 5. Social Security Number<br><b>217-18-7893</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>98</b> Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.  |  |
|  | 8. Date of Birth<br>Month <b>Aug.</b> Day <b>2</b> , Year <b>1902</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Frederick</b>   |  | 10c. City, Town or Location<br><b>Frederick</b>                         |  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>733 Motter Avenue</b>  |  |  |  | 10f. Zip Code<br><b>21701</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assembly Line</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Electrical</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Wilbur Rinehart</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ada Brust</b>  |  |   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donald M. Lantz, son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8104 Clearfield Rd., Frederick, Md. 21702</b>  |  |   |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mount Olivet Cemetery, Sept. 12, 2000</b>  |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>  |  |   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Richard E. [Signature]</b> M00255  |  | 22. Name and Address of Facility<br><b>Keeney and Bastford P.A. Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>  |  |  |  |   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | a. <b>DEHYDRATION</b><br>Due to (or as a consequence of):   |  |  |  | WEEKS   |  |   |  |
|  | b. <b>INANITION</b><br>Due to (or as a consequence of):  |  | WEEKS   |  |  |  |   |  |   |  |
|  | c. <b>DEMENTIA</b><br>Due to (or as a consequence of):   |  | YEARS   |  |  |  |   |  |   |  |
| d.   |  |  |   |  |  |  |   |  |   |  |
| To Be Completed by<br>Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b><br><b>PACEMAKER</b><br><b>HYPERTENSION</b>   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |   |  |
|  |  |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred                                       |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |  | 29b. Signature and title of certifier<br><b>[Signature]</b> MD  |  |  |  | 29c. License number<br><b>D47556</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>September 11, 2000</b>        |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>WILLIAM H. JOHNSON MD, 172 THOMAS JOHNSON DRIVE FREDERICK MD 21702</b>  |  |   |  |  |  |   |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |   |  |   |  |
|  | State Registrar  |  |   |  |  |  |   |  |   |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 30364

Amend #23-Pt2,9/19/2000,BMW, Montg. Co.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ann M. Murphy

2. Date of Death

Month Day Year  
September 8, 2000

3. Time of Death

0245

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

214-48-6917

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 13, 1924 Washington, D.C.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13205 Betty Lane

10f. Zip Code

20904

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

School Librarian

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Thomas Francis Clark

18. Mother's Name (First, Middle, Maiden Surname)

Anna Riff

19a. Informant's Name/Relationship (Type, Print)

Thomas D. Murphy (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13205 Betty Lane Silver Spring, Maryland 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery 9/11/00 Silver Spring, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. Keis Skiles

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e.

ASPIRATION PNEUMONIA

20 days

Due to (or as a consequence of):

b.

SEPSIS

1 WEEK

Due to (or as a consequence of):

c.

RENAL FAILURE

2 DAYS

Due to (or as a consequence of):

d.

RESPIRATORY FAILURE

IMMEDIATE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Recurrent Aspiration Pneumonia,  
DEMENTIA, RECURRENT ASPIRATION,

CHF, PACEMAKER,

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Sangeeta Simlote, M.D.

29c. License number

D50276

29d. Date signed (Month, Day, Year)

SEPTEMBER 8, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SANGEETA SIMLOTE, MD, 17904 GEORGIA AVE #304 OLNEY MD 20832

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

24



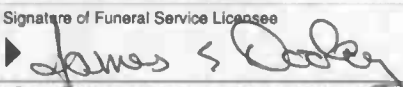
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30365

|  |   |   |   |   |  |  |  |  |  |
|--|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Ellen Shea Moreland   |   |   |   | 2. Date of Death<br>Month Day Year<br>SEPT 12 2000   |  | 3. Time of Death<br>11:30 pm   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>4002 CHARIOT'S FLIGHT WAY   |   |   |   | 4b. City, Town, or Location of Death<br>ELLCOTT CITY   |  | 4c. County of Death<br>HOWARD  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>579-22-1839  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>83 Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Apr 22, 1917                                  |  | 9. Birthplace (State or Foreign Country)<br>New York   |  |
|  | Usual Residence of Decedent   |   |   |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  |   | 10b. County<br>Howard   |   | 10c. City, Town or Location<br>Ellicott City   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |
|  | 10e. Street and Number<br>4002 Chariot's Flight Way   |   |   |   | 10f. Zip Code<br>21043   |  | 10g. Citizen of What Country?<br>USA   |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 12   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Bookkeeper                               |   | 16b. Kind of Business/Industry<br>Parish Administrator   |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Simon Timothy Shea   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Julia T. Kelly  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Jeffrey Moreland / Son  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>503 Alta Drive, Fort Worth, TX 76107  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |   | 20c. Location - City or Town, State<br>Silver Spring, MD   |  | 20d. Date<br>9/15/00   |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   |   |   | 22. Name and Address of Facility<br>Francis J. Collins Funeral Home, Inc.<br>500 University Blvd., W, Silver Spring, MD 20901  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. ADENOCARCINOMA OF PLEURA<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |   |   |   |  |  |  | Approximate Interval Between Onset and Death<br>2 mos. |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____<br>_____   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                      |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |   | 28i. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br>D0018317   |  | 29d. Date signed (Month, Day, Year)<br>SEPT 13 2000                                  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>BERNARD P. FARRELL MD<br>11055 LITTLE PATUXENT PARKWAY, COLUMBIA, MD 21044   |   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 15 2000   |   | 32. Registrar's Signature<br>   |   |   |  |  |  |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30366

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHRISTOPHER TODD MOORE

2. Date of Death

SEPTEMBER 08, 2000

3. Time of Death

8:44 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MONTGOMERY GENERAL

4b. City, Town, or Location of Death

OLNEY

4c. County of Death

MONTGOMERY

5. Social Security Number

215-66-9718

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

38

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 5, 1962

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

17536 Queen Elizabeth Drive

10f. Zip Code

20832

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Ted C. Moore

18. Mother's Name (First, Middle, Maiden Surname)

Betty Meacham

19a. Informant's Name/Relationship (Type, Print)

Betty M. Moore (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17536 Queen Elizabeth Drive Olney, Maryland 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Pleasant Church Cemetery

Date

9/15/00

20c. Location - City or Town, State

Ellerbe, NC

21. Signature of Funeral Service Licensee

Robert C. Ramsey

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple Injuries  
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural  
2 ☒ Accident  
3 ☐ Suicide  
4 ☐ Homicide

5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

9-8-00

28b. Time of Injury

19 38 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Motorcycle collide with auto

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Layhill Drive

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

SEPTEMBER 09, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30367

## Certificate of Death

Reg. No.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET MIHUC</b>  |   | 2. Date of Death<br>Month Day Year<br><b>9-9-2000</b>   |  | 3. Time of Death<br><b>9:05P.</b>                     |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sligo Creek Nursing and Rehabilitation Ctr.</b> |   | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>  |  | 4c. County of Death<br><b>Montgomery</b>              |
| Funeral<br>Director   | 5. Social Security Number<br><b>172-07-6812</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                        |
|   | 8. Date of Birth (Month, Day, Year)<br><b>July 7, 1915</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |  |   |
| Usual Residence of Decedent   |  |   |   |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Takoma Park</b>  |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |   |  |   |
| 10e. Street and Number<br><b>8101 Hammond Avenue</b>  |  |   | 10f. Zip Code<br><b>20912</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Librarian</b>   |   | 16b. Kind of Business/Industry<br><b>Univ. of Maryland</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Michael Mihuc</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Skibo</b>  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph William Mihuc (brother)</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b> |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b>  |   |
| 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |   |  |   |
| Immediate Cause (Final disease or condition resulting in death)   |  | a. <b>Aspiration pneumonia</b><br>Due to (or as a consequence of):  |   | Approximate Interval Between Onset and Death<br><b>1 day</b>   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |  | b. <b>Neurogenic dysphagia</b><br>Due to (or as a consequence of):  |   | <b>years</b>   |   |
|   |  | c. <b>Cerebrovascular disease</b><br>Due to (or as a consequence of):   |   | <b>years</b>   |   |
|   |  | d.  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |   |
|   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |
| 29b. Signature and title of certifier<br><b>Norton Elson MD</b>   |  | 29c. License number<br><b>D20362</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>Sept 10, 2000</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Norton Elson 0525 Belcrest Rd #208 Hyattsville MD 20782</b>  |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |  | 32. Registrar's Signature<br><b>Barbara B. Sparks</b>   |   |  |   |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30368

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY MATOSIAN

2. Date of Death  
Month Day Year  
SEPTEMBER 8, 20003. Time of Death  
11:35 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST NURSING &amp; REHAB. CT.

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-84-5087

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 15 1905

9. Birthplace (State or Foreign Country)

Turkey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7616 Warbler Lane

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unknown

Bezdekian

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Rose M. Werner / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7616 Warbler Lane, Derwood, Maryland 20855

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

9/12/00

20c. Location - City or Town, State

Silver Spring, Md.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home  
P. O. Box 5038, Laytonsville, Maryland 2088223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

BRAIN TUMOR

Approximate  
Interval Between  
Onset and Death

3 YEARS.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John P. Casey MD

29c. License number

D 43243

29d. Date signed (Month, Day, Year)

SEPT 9TH 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN P. CASEY MD.

11119 ROCKVILLE PIKE #320  
ROCKVILLE MD 20852

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #27, 9/12/2000, per MD, JW, Mont. Co. **Certificate of Death**

Reg. No.

00 30369

|  |  |   |  |  |   |   |  |   |
|--|--|---|--|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LARISA MARYANCHIK</b>                       |   |  |  | 2. Date of Death<br>Month <b>AUG</b> Day <b>25</b> Year <b>2000</b> |   | 3. Time of Death<br><b>12:20 PM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>             |   | 4c. County of Death<br><b>MONTGOMERY</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-17-5428</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>86</b> Yrs.                    |   | 8. Date of Birth (Month, Day, Year)<br><b>JAN 1, 1914</b>                                      |   |
|  | 10a. State<br><b>MD</b>  |   | 10b. County<br><b>MONTGOMERY</b>   |  | 10c. City, Town or Location<br><b>ROCKVILLE</b>                     |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>6121 MONTROSE RD</b>  |  |   |  | 10f. Zip Code<br><b>20852</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>  |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>ISAAC MARYANCHIK</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHIFRA FEINBERG</b>  |   |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>IRENE LESHCHINER DAUGHTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4715 IRIS ST, ROCKVILLE, MD 20853</b>  |   |   |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GDNS</b>   |  | Date<br><b>8-27-00</b>   |   | 20c. Location - City or Town, State<br><b>OLNEY, MD</b>                                     |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Ronald W. Ruenbury</i>   |  |   |  | 22. Name and Address of Facility<br><b>DANZANSKY GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>  |   |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Fracture of Nasal Septum</b><br>Due to (or as a consequence of):<br>c. <b>Fractures of Cervical Spine</b><br>Due to (or as a consequence of):<br>d. <b>md DME</b> |  |   |  |  |   |   |  | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause listed in Part I.<br><i>Am 9/5/00</i>  |  |   |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>August 18, 2000</b>  |  | 28b. Time of Injury<br><b>PM</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>Resident ran into a wall and fell</b>   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                      |  | 29b. Signature and title of certifier<br><i>KR Lillie MD</i>  |  | 29c. License number<br><b>D53244</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>August 25, 2000</b>                               |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Katharine R. Lillie, MD 11140 Rockville Pike, PMB 348, Rockville, MD 20852</b>  |  |   |  |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |  |  |   |   |  |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30370

## Certificate of Death

Reg. No.

|   |  |                            |   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
|---|--|----------------------------|---|---|--|--------------------------|--|--|--|--|---|----|----------------------------|---|----|--------------------|----|--|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Louise Main</b>   |                            |   |   | 2. Date of Death<br>Month <b>September</b> Day <b>10</b> Year <b>2000</b>  |                          |  |  | 3. Time of Death<br><b>1:45 PM</b>   |  |   |    |                            |   |    |                    |    |  |    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>1504 West Eighth Street</b>   |                            |   |   | 4b. City, Town, or Location of Death<br><b>Frederick</b>   |                          |  |  | 4c. County of Death<br><b>Frederick</b>  |  |   |    |                            |   |    |                    |    |  |    |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-14-5306</b>  |                            | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.   |                          | 8. Date of Birth<br>Month <b>June</b> Day <b>28</b> Year <b>1921</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |  |   |    |                            |   |    |                    |    |  |    |
|   | Usual Residence of Decedent  |                            |   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |                            | 10b. County<br><b>Frederick</b>   |   | 10c. City, Town or Location<br><b>Frederick</b>  |                          |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |    |                            |   |    |                    |    |  |    |
|   | 10e. Street and Number<br><b>1504 West Eight Street</b>  |                            |   |   | 10f. Zip Code<br><b>21702</b>  |                          | 10g. Citizen of What Country?<br><b>U.S.A.</b>                       |  |  |  |   |    |                            |   |    |                    |    |  |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |   |    |                            |   |    |                    |    |  |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____   |                            |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |                          |  |  | 16b. Kind of Business/Industry<br><b>Public School System</b>                                  |  |   |    |                            |   |    |                    |    |  |    |
|   | 17. Father's Name (First, Middle, Last)<br><b>John W. Wachter</b>  |                            |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Isabelle Lambert</b>   |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br><b>James E. Main/Son</b>   |                            |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7220 Edgemont Road, Frederick, Maryland 21702</b>  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                            |   |   | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>St. Paul's Cemetery</b>  |                          |  |  | 20c. Location - City or Town, State<br><b>Sept. 13, 2000 Utica, Maryland</b>                   |  |   |    |                            |   |    |                    |    |  |    |
|   | 21. Signature of Funeral Service Licensee<br><i>Richard C. Basford</i> MD00021   |                            |   |   | 22. Name and Address of Facility<br><b>Keeney and Basford P.A. Funeral Home</b><br><b>106 East Church St., Frederick, Md. 21701</b>  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |                            |   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Respiratory Failure</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>Days</b><br/><br/> <b>2 years</b> </td> </tr> <tr> <td>b.</td> <td><b>Lung Cancer</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |                            |   |   |  |                          |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Respiratory Failure</b> | Approximate Interval Between Onset and Death<br><br><b>Days</b><br><br><b>2 years</b> | b. | <b>Lung Cancer</b> | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.   | <b>Respiratory Failure</b> | Approximate Interval Between Onset and Death<br><br><b>Days</b><br><br><b>2 years</b>   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
|   | b.   | <b>Lung Cancer</b>         |   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
|   | c.   |                            |   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
|   | d.   |                            |   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                            |   |   |  |                          |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |    |                            |   |    |                    |    |  |    |
|   |  |                            |   |   |  |                          |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |    |                            |   |    |                    |    |  |    |
|   |  |                            |   |   |  |                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |    |                            |   |    |                    |    |  |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                            |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |                            |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |    |                            |   |    |                    |    |  |    |
|   |  |                            |   | 28d. Describe how injury occurred   |  |                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |    |                            |   |    |                    |    |  |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                            |   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
| 29b. Signature and title of certifier<br><i>K. Basford, MD</i>  |  |                            |   | 29c. License number<br><b>D 41866</b>   |  |                          |  | 29d. Date signed (Month, Day, Year)<br><b>September 11, 2000</b>   |  |  |   |    |                            |   |    |                    |    |  |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kenan Hudhud, MD 801 Tollhouse Ave, F Frederick, MD 21701</b>  |  |                            |   |   |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |  |                            |   | 32. Registrar's Signature<br><i>Kenan Hudhud</i>  |  |                          |  |  |  |  |   |    |                            |   |    |                    |    |  |    |

ORIGINAL





Amended # 206

ACHD 09/13/00 mlu

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30371

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ERMA JEAN MAWHINNEY

2. Date of Death  
Month Day Year

September 10, 2000

3. Time of Death

23:00 P.M.

4a. Facility Name (If not institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

218-24-8020

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 19, 1928

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

CUMBERLAND

10d. Inside City Limits

☒ Yes 2 ☐ No

10a. Street and Number

733 GEPHART DRIVE

10f. Zip Code

21502

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SITTER

16b. Kind of Business/Industry

PRIVATE DUTY

17. Father's Name (First, Middle, Last)

HERMAN LITTLE

18. Mother's Name (First, Middle, Maiden Surname)

MARY POLLOCK

19a. Informant's Name/Relationship (Type, Print)

SHEILA ABE / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14101 STREETT ROAD, N.E., FLINTSTOE, MD 21530

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

SUNSET MEMORIAL PARK

Date

9/13/2000

(2:15 PM)

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

Sheila A. Abe

22. Name and Address of Facility

UPCHURCH FUNERAL HOME, P.A.

202 GREENE ST., CUMBERLAND, MD 21502

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute Sepsis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sheila A. Abe MD

29c. License number

D22181

29d. Date signed (Month, Day, Year)

September 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary Wagoner, M.D. 925 Bishop Walsh Rd Cumberland MD 21502

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30372

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHRISTINA N. MURPHY

2. Date of Death

September 13, 2000

3. Time of Death

7:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

EGLE NURSING HOME

4b. City, Town, or Location of Death

LONACONING

4c. County of Death

ALLEGANY

5. Social Security Number

217-10-6127

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

November 12, 1915

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

ALLEGANY

10c. City, Town or Location

LONACONING

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

57 JACKSON STREET

10f. Zip Code

21539

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABOR

16b. Kind of Business/Industry

TEXTILE

17. Father's Name (First, Middle, Last)

ANDREW NICOL

18. Mother's Name (First, Middle, Maiden Surname)

DELLA DONALD

19a. Informant's Name/Relationship (Type, Print)

PATRICIA GRINDLE DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

58 W. MAIN STREET LONACONING, MD 21539

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FROSTBURG MEMORIAL PARK

Date

September 15, 2000

20c. Location - City or Town, State

FROSTBURG MD

21. Signature of Funeral Service Licensee

► *James E. McKenzie*

22. Name and Address of Facility

Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21539

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *PNEUMONIA*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*2 WEEKS*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*ADVANCED DEMENTIA*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *Chang Hyun Oh*

29c. License number

*D24951*

29d. Date signed (Month, Day, Year)

09/12/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chang Hyun Oh, M.D., 48 Tarn Terrace, Suite 204, Frostburg, Md. 21532

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

NO

1000 1000 1000

1000 1000 1000

1000 1000 1000

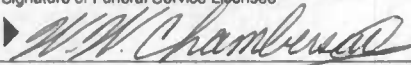
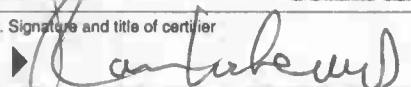

DAVID NITOWITZ

State of Maryland / Department of Health and Mental Hygiene

ASP amend item 23a,27,28a,b,c,d,e,f per me G787 9/27/00 **Certificate of Death**

Reg. No.

00 30373

|   |   |   |  |  |                                    |
|---|---|---|--|--|------------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DAVID H. NITOWITZ</b>                            |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 10 2000</b> |  | 3. Time of Death<br><b>00:05</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>DEATON SPECIALTY HOUSE</b> |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>       |  | 4c. County of Death<br><b>NONE</b> |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-22-7099</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.               | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 18, 1925</b>   |                                    |
|   | 9. Birthplace (State or Foreign Country)<br><b>WASH. D.C.</b>                                   |   | 10a. State<br><b>MD.</b>                                       |  |                                    |
| 10b. County<br><b>PRINCE GEORGES</b>  |   | 10c. City, Town or Location<br><b>COLLEGE PARK</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                    |
| 10e. Street and Number<br><b>4712 CHEROKEE ST. #104</b>   |   | 10f. Zip Code<br><b>20740</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |                                    |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                    |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>TECHNICIAN</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NAVAL ORDINANCE LAB.</b>   |                                    |
| 17. Father's Name (First, Middle, Last)<br><b>ISADORE NITOWITZ</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSE GOODMAN</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>MIKE NITOWITZ/SON</b>   |                                    |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>145 25th ST., COPIAGUE, N.Y. 11726</b>  |   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ARLINGTON NAT'L. CEM. 9/19/00</b>   |                                    |
| 20c. Location - City or Town, State<br><b>ARLINGTON, VA.</b>  |   | 21. Signature of Funeral Service Licensee<br> <b>MO0091</b>   |  | 22. Name and Address of Facility<br><b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>  |                                    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. MULTIPLE INJURIES WITH COMPLICATIONS</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |   | Approximate Interval Between Onset and Death  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown        |                                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |                                    |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                    |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>5/11/00</b>  |  | 28b. Time of Injury<br><b>8:33 P M</b>   |                                    |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred<br><b>pedestrian struck by auto</b>   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore Ave. near Cherokee St., College Park, Md</b>  |                                    |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E</b>  |                                    |
| 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 11, 2000</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Allen Labe, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |                                    |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>   |   | 32. Registrar's Signature<br>   |  |  |                                    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30374

|   |  |   |  |  |   |   |  |  |
|---|--|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Margret Nesmith</u>                                       |   |  |  | 2. Date of Death<br>Month <u>September</u> Day <u>10</u> Year <u>2000</u> |   | 3. Time of Death<br><u>1147AM</u>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>Prince George's Hospital Center</u> |   |  |  | 4b. City, Town, or Location of Death<br><u>Cheverly</u>                   |   | 4c. County of Death<br><u>Prince George's</u>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>579-05-6333</u>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>84</u> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><u>6/3/1916</u>   | 9. Birthplace (State or Foreign Country)<br><u>N.C.</u>  |
|   | Usual Residence of Decedent  |   |  |  |   |   |  |  |
| 10e. State<br><u>MD</u>   |  | 10b. County<br><u>Prince Georges</u>  |  | 10c. City, Town or Location<br><u>Capitol Heights</u>  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><u>411 Millwoof Drive</u>   |  |   |  | 10f. Zip Code<br><u>20743</u>  |   | 10g. Citizen of What Country?<br><u>U.S.A.</u>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>4yrs</u> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Teacher</u>  |   | 16b. Kind of Business/Industry<br><u>Education</u>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>James Mc Neil</u>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Maggie Blackman</u>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Bobby L. Nesmith /son</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>411 Millwoof Drive, Capitol Heights, Md. 20743</u>                                       |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Fort Lincoln</u>   |  | Date<br><u>9/16/00</u>   |   | 20c. Location - City or Town, State<br><u>Bladensburg, MD</u>   |  |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u> CC0348  |  |   |  | 22. Name and Address of Facility<br><u>Latney's Funeral Home Inc. 3831 Georgia Avenue, N.W. Wash., DC 20011</u>  |   |   |  |  |
| 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Cause (Final disease or condition resulting in death)<br>a. <u>Atherosclerotic Cardiovascular Disease</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |   |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>   |  |   |  | 29c. License number<br><u>H0055927</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>September 12, 2000</u>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Salvador Sylvestre, 3001 Hospital Drive, Cheverly, Maryland 20785</u>  |  |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>SEP 15 2000</u>   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |  |   |   |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30375

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD P. ODUM

2. Date of Death

Month Day Year  
Sept. 10, 2000

3. Time of Death

7:15 AM

4e. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

214-03-8113

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Apr. 16 1913

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18213 Hillcrest Avenue

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11College (1-4 or 5+)  
0

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sheet Metal Worker

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Burley Odum

18. Mother's Name (First, Middle, Maiden Surname)

Anna King

19a. Informant's Name/Relationship (Type, Print)

Doris M. Odum / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18213 Hillcrest Avenue, Olney, Maryland 20832

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

9/14/00

20c. Location - City or Town, State

Silver Spring, Md.

21. Signature of Funeral Service Licensee

Muriel H. Barber

22. Name and Address of Facility

Muriel H. Barber Funeral Home  
P.O. Box 5038, Laytonsville, Maryland 20882

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

BRONCHO PNEUMONIA

Approximate Interval Between Onset and Death

72 HRS

b.

Due to (or as a consequence of):

PARKINSON'S DISEASE

7 YEARS

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA, SEVERE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Donald R. Lewis M.D.

29c. License number

D06406

29d. Date signed (Month, Day, Year)

SEPTEMBER 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DONALD R. LEWIS MD 4000 RT108 OLNEY, MD 20832

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



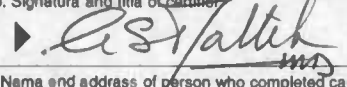
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30376

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Eleanor Watkins Offutt</b>                               |   | 2. Date of Death<br>Month: <b>Sept.</b> Day: <b>12</b> Year: <b>2000</b>     |  | 3. Time of Death<br><b>4:30pm</b>                     |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>                     |  | 4c. County of Death<br><b>MONTGOMERY</b>              |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-46-8755</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                             | If Under 1 Year<br>Months: Days:   | If Under 24 Hrs.<br>Hours: Min.                       |
|  | 8. Date of Birth (Month, Day, Year)<br><b>May 31, 1922</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                  |  |   |
| Usual Residence of Decedent  |   |   |  |  |   |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Germantown</b>   |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |
| 10e. Street and Number<br><b>23339 Davis Mill Road</b>   |   |   | 10f. Zip Code<br><b>20876</b>  |  | 10g. Citizen of What Country?<br><b>United States</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>   |  | 16b. Kind of Business/Industry<br><b>National Institutes of Mental Health</b>  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Lee Watkins Jr.</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosie M. Johnson</b> |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margo Karbacher/ niece</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>33333 Pewter Road, Aqua Dulce, California 91350</b>   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Upper Seneca Baptist Cem.</b>  |  | 20c. Location - City or Town, State<br><b>9/16/00 Germantown, Maryland</b>   |   |
| 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Olin L. Molesworth P. A. Funeral Home</b><br><b>26401 Ridge Road, Damascus, Maryland 20872</b>   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)  |   | Approximate Interval Between Onset and Death  |  |  |   |
| a. <b>Cerebral Hemorrhage</b>  |   | <b>5 days</b>   |  |  |   |
| b. <b>Cerebral Aneurysm</b>  |   |   |  |  |   |
| c. <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>   |   |   |  |  |   |
| d. <b>Due to (or as a consequence of):</b>   |   |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  |  |   |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |   |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>0055687</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 13, 2000</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Gunwant Mallik, M. D. 198 Thomas Johnson Drive, Frederick, Maryland 21702</b>   |   |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>  |   | 32. Registrar's Signature<br>   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30377

Amended item #3 09/13/2000 FCHD, KS Certificate of Death

Reg. No.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>George P. Orye</b>   |  | 2. Date of Death<br>Month <b>September</b> Day <b>11</b> Year <b>2000</b>   |  | 3. Time of Death<br><b>5:09AM</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>10 East "E" Street</b>   |  | 4b. City, Town, or Location of Death<br><b>Brunswick</b>  |  | 4c. County of Death<br><b>Frederick</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-40-3516</b>   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Aug 15 1942</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Brunswick MD</b>   |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |  |   |  |  |
|   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Frederick</b>  | 10c. City, Town or Location<br><b>Brunswick</b>   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>10 East "E" Street</b>   |  | 10f. Zip Code<br><b>21716</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Electrician</b>   |  | 16b. Kind of Business/Industry<br><b>J.J. Crewe &amp; Sons Inc<br/>Buckeystown, MD</b>  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Clement David Orye</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Naomi Beatrice Harsh</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia L. Orye, Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 East "E" Street, Brunswick, MD 21716</b>   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resthaven Memorial Gardens</b>   |  | 20c. Location - City or Town, State<br><b>Frederick, MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Barbara A. Williams, Owner</b>  |  | 22. Name and Address of Facility<br><b>John T. Williams Funeral Home<br/>100 Petersville Road, Brunswick, MD 21716</b>  |  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  | Approximate Interval Between Onset and Death   |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>a. ASCVD</b>  |  |   |  | <b>years</b>   |
|   | Due to (or as a consequence of):  |  |   |  |  |
|   | Due to (or as a consequence of):  |  |   |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>1</b> Yes 2 <input type="checkbox"/> No  |
| 28c. Describe how injury occurred   |   | 28d. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>Andrew Zarick, Jr.</b>  |   | 29c. License number<br><b>D35164</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>September 13, 2000</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andrew Zarick, Jr. MD 1080 W. Patrick St Frederick, MD 21703</b>   |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |   | 32. Registrar's Signature<br><b>B. [Signature]</b>                             |   |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

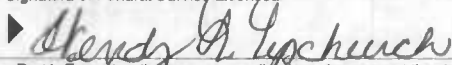
## Certificate of Death

Reg. No.

00 30378

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|  |  |   |  |   |  |  |  |  |  |  |  |   |  |
|--|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Marie Opal O'Neal</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>September 7, 2000</b>  |  |  |  | 3. Time of Death<br><b>12:50 PM</b>  |  |  |  |   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Allegany County Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>   |  |  |  | 4c. County of Death<br><b>Allegany</b>   |  |  |  |   |  |
| 5. Social Security Number<br><b>212-18-1783</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 23, 1921</b>  |  |   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |   |  |  |  |  |  |  |  |   |  |
| Usual Residence of Decedent  |  |   |  |   |  |  |  |  |  |  |  |   |  |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Allegany</b>  |  | 10c. City, Town or Location<br><b>Cumberland</b>  |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |   |  |
| 10e. Street and Number<br><b>132 Grand Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21502</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> Collega (1-4 or 5+) <b></b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Union Rescue and Goodwill Industries</b>                  |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ralph F. Knippenberg</b>   |  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna R. McCarty</b>  |  |  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Roy F. Owens, Jr./Son-in-law</b>  |  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12602 Valley View Avenue, Cresaptown, MD 21502</b> |  |  |  |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>   |  |  |  | Date<br><b>9/11/2000</b>   |  | 20c. Location - City or Town, State<br><b>Cumberland, MD</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  |   |  | 22. Name and Address of Facility<br><b>Upchurch Funeral Home, P.A.<br/>202 Greene Street, Cumberland, MD 21502</b>                                     |  |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ADENOCARCINOMA, LUNG</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |   |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>ONE yr</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>THORACIC AORTIC ANEURYSM</b>  |  |   |  |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |  |
| 24a. Were en autopsies performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  | 28d. Describe how injury occurred  |  |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D-14865</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPT, 7, 2000</b>  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robustiano J. Barrera, M.D. - 500 Memorial Avenue, Cumberland, MD 21502</b>   |  |   |  |   |  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30379

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIOLA PUMPHREY

2. Date of Death

Month Day Year  
SEPT. 12, 2000

3. Time of Death

5:30 PM

4a. Facility Name (If not institution, give street and number)

13923 Castle Blvd., #13

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

213-40-7347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

61 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 21, 1939

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3616 Bel Pre Road, #T-1

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Aide

16b. Kind of Business/Industry

Montg. Co.

Schools

17. Father's Name (First, Middle, Last)

Clarence L. Greenlee

18. Mother's Name (First, Middle, Maiden Surname)

Louise Carter

19a. Informant's Name/Relationship (Type, Print)

Sherry Meshesha (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13923 Castle Blvd., Silver Spring, MD 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Norbeck Mem. Park

Date

9/20/00

20c. Location - City or Town, State

Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC BREAST CANCER

Approximate Interval Between Onset and Death

2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Daughters Home

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 35635

29d. Date signed (Month, Day, Year)

SEPTEMBER 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan 18111 Prince Philip Dr Olney, MD 20832

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30380

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nicholas H. Piegari

2. Date of Death  
Month Day Year  
September 6, 20003. Time of Death  
4:40 PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

119-09-8637

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan. 2, 1918

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Ashton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1309 Patuxent Drive

10f. Zip Code

20861

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Metalurgist

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

John Piegari

18. Mother's Name (First, Middle, Maiden Surname)

Julia Kask

19a. Informant's Name/Relationship (Type, Print)

Barbara Piegari / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1309 Patuxent Drive, Ashton, Maryland 20861

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory 09/12/00 Brentwood, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary Embolus

Due to (or as a consequence of):

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 33067

29d. Date signed (Month, Day, Year)

September 6th 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Collins MD 18111 Prince Philip Dr Olney, Maryland 20832

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30381

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Verna C. Philps

2. Date of Death

Month Day Year  
September 7, 2000

3. Time of Death

7:34pm

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

187-22-2605

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 2, 1906

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Derwood

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7641 Miller Fall Road

10f. Zip Code

20855

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Virgil Castelli

18. Mother's Name (First, Middle, Maiden Surname)

Amelia Gilaganni

19a. Informant's Name/Relationship (Type, Print)

Gloria Sailer (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7641 Miller Fall Road, Derwood, MD 20855

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

9/8/00

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure

1 Day

Due to (or as a consequence of):

b. Massive Stroke (Ischemic)

3 Day

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d. Atherosclerotic Heart Disease

Years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical ExaminerOn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

039372

29d. Date signed (Month, Day, Year)

September 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rashid Baghai, MD 344 University Blvd., West Suite 324, Silver Spring, MD 20901

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural" or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30382

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MIRIAM A. PHIBBS

2. Date of Death

September 11 2000

3. Time of Death

6:25 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

578-92-1767

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 3, 1909

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

MD.

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7355 FURNACE BRANCH RD.

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

UNK.

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

NEVER WORKED

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

THOMAS PHIBBS

18. Mother's Name (First, Middle, Maiden Surname)

MAMIE W. JACKSON

19a. Informant's Name/Relationship (Type, Print)

MARTHA B. BUCHANAN/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6509 KANSAS LANE, TAKOMA PARK, MD. 20912

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

9/12/00

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

M. W. Chambers

22. Name and Address of Facility

MOOO91 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

George E. Wicks MD

29c. License number

D41365

29d. Date signed (Month, Day, Year)

September 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wicks MD, 301 Hospital Drive, Glen Burnie 21061

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Marian A Phibbs

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 30383

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jean G. Runfola

2. Date of Death

Month Day Year  
September 13, 2000 10:43 am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-56-4369

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 18, 1941

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11206 Mitscher Street

10f. Zip Code

20895

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Albert F. Gilson

18. Mother's Name (First, Middle, Maiden Surname)

Catherine J. Smyrnas

19a. Informant's Name/Relationship (Type, Print)

Stephanie J. Runfola / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11206 Mitscher Street, Kensington, MD 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

9/18/00 Rockville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

J. Ken Skile

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W. Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Hepatic Cirrhosis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 month

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ascites

Esophageal Varices

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Barry Rubin

29c. License number

D 47499

29d. Date signed (Month, Day, Year)

September 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry Rubin, MD 10801 Lockwood Drive, #200, Silver Spring, MD 20901

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30384

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Gladys Carolyn Roser

2. Date of Death  
Month Day Year  
September 6, 2000

3. Time of Death  
12:40PM

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

577-22-5162

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 11, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5925 Anniston Road

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Support Services

16b. Kind of Business/Industry

Montgomery County Public Schools

17. Father's Name (First, Middle, Last)

James Patrick Ehrman

18. Mother's Name (First, Middle, Maiden Surname)

Katherine Moeller

19a. Informant's Name/Relationship (Type, Print)

Charles E. Roser/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5925 Anniston Road, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

Sept. 9 2000

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

*David E. Perry* M00803

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Bethesda-Chevy Chase, Inc. 7557 Wisconsin  
Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma

3 Months

Due to (or as a consequence of):

b. Cancer of Ovary

2 Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*E. P. Libre MD*

29c. License number

D09470

29d. Date signed (Month, Day, Year)

September 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene P. Libre, M.D. 10400 Connecticut Avenue, Kensington, Maryland 20895

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

*B. Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

15






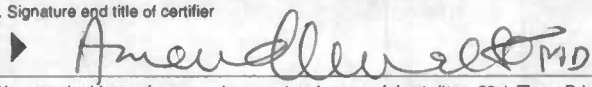
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30385

|   |  |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
|---|--|---------------------------------------|---|---|---|---|--|-----------------------------------|---|----|------------------------------|---------------|----------------------------------|--|--|----|------------------|---------------|----------------------------------|--|--|----|----------------------------|-----------------|----------------------------------|--|--|----|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Abelardo Rodriguez</b>                    |                                       |   |   | 2. Date of Death<br>Month Day Year<br><b>September 5, 2000</b>  |   | 3. Time of Death<br><b>11:20 AM</b>  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Woodside Center</b> |                                       |   |   | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |   | 4c. County of Death<br><b>Montgomery</b>   |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>083-32-5826</b>  |                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>June 27, 1933</b>  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
|   | 10a. State<br><b>Maryland</b>  |                                       | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Silver Spring</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| Usual Residence of Decedent   |  |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 10e. Street and Number<br><b>11700 Old Columbia Pike, #710</b>  |  |                                       |   | 10f. Zip Code<br><b>20904</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Uruguayan</b> |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Hispanic</b>   |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>5+</b>   |  |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Retailer</b>  |   | 16b. Kind of Business/Industry<br><b>Hecht's</b>  |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Abelardo Lorenzo Rodriguez</b>  |  |                                       |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Haydee Ferreiros</b>  |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Margarita A. Rodriguez / Wife</b>  |  |                                       |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11700 Old Columbia Pike, #710, Silver Spring, MD 20904</b>  |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                       |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Crematory</b>   |   | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>                           |  | 20d. Date<br><b>09/08/00</b>      |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                       |   | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Avenue<br/>Silver Spring, Maryland 20904</b>  |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Myocardial Infarction</b></td> <td><b>1 hour</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td><b>Pneumonia</b></td> <td><b>7 days</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td><b>Parkinson's disease</b></td> <td><b>10 years</b></td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table> |  |                                       |   |   |   |   |  |                                   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Myocardial Infarction</b> | <b>1 hour</b> | Due to (or as a consequence of): |  |  | b. | <b>Pneumonia</b> | <b>7 days</b> | Due to (or as a consequence of): |  |  | c. | <b>Parkinson's disease</b> | <b>10 years</b> | Due to (or as a consequence of): |  |  | d. |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.   | <b>Myocardial Infarction</b>          | <b>1 hour</b>   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
|   | Due to (or as a consequence of):   |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
|   | b.   | <b>Pneumonia</b>                      | <b>7 days</b>   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
|   | Due to (or as a consequence of):   |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| c.  | <b>Parkinson's disease</b>   | <b>10 years</b>                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| Due to (or as a consequence of):  |  |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| d.  |  |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                       |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
|   |  |                                       |   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
|   |  |                                       |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                       |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                       |   | 28t. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 29b. Signature and title of certifier<br>  |  |                                       |   | 29c. License number<br><b>D38262</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>September 6, 2000</b>                             |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Mendhiratta 2401 Research Blvd., Suite 340, Rockville, Maryland 20854</b>  |  |                                       |   |   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 11 2000</b>   |  |                                       |   | 32. Registrar's Signature<br>   |   |   |  |                                   |   |    |                              |               |                                  |  |  |    |                  |               |                                  |  |  |    |                            |                 |                                  |  |  |    |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30386

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALICE RAEFSKY

2. Date of Death

Month Day Year  
SEPT 09, 2000

3. Time of Death

6:18 PM

4a. Facility Name (If not Institution, give street and number)

CASEY HOUSE HOSPICE

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

167-28-9698

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 13, 1928

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6102 NEILWOOD DRIVE

10f. Zip Code

20852-3706

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

EDITOR

16b. Kind of Business/Industry

SCIENTIFIC JOURNAL  
PUBLICATION

17. Father's Name (First, Middle, Last)

MORRIS RAEFSKY

18. Mother's Name (First, Middle, Maiden Surname)

SARAH KARP

19a. Informant's Name/Relationship (Type, Print)

ESTELLE R. ALEXANDER/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6102 NEILWOOD DRIVE, ROCKVILLE, MARYLAND 20852-3706

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
CREMAT, SEPT 11,  
NATIONAL FUNERAL HOME CR 2000

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) HOSPICE

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0037620

29d. Date signed (Month, Day, Year)

SEPT 9, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK S. GODEC, MD, CASEY HOUSE, 6001 MUNCASTER MILL RD, ROCKVILLE, MD 20855

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30387

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>BERNARD EARL RADUNSKIE</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>SEP 9 2000</b>  |  | 3. Time of Death<br><b>6:43 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| 5. Social Security Number<br><b>472-20-1352</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 29, 1926</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>Minnesota</b>  |  | 10a. State<br><b>PA</b>  |  | 10b. County<br><b>Adams</b>  |  | 10c. City, Town or Location<br><b>Carroll Valley</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>6 Dandelion Trail NW</b>  |  | 10f. Zip Code<br><b>17320</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Korea &amp; WWII</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sergeant Major</b>   |  | 16b. Kind of Business/Industry<br><b>US Army</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Carl Radunske</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lisbeth Gardner</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James R. Radunske - Son</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 Violet Ct. Rochester, NH. 03867</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem.</b>  |  | 20c. Location - City or Town, State<br><b>Arlington, Virginia</b>  |  | 20d. Date<br><b>9/27/00</b>  |  | 21. Signature of Funeral Service Licensee<br>  |  |
| 22. Name and Address of Facility<br><b>Metropolitan Funeral Service, Inc.<br/>5517 Vine Street Alexandria, VA 22310</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. METASTATIC TRANSITIONAL CELL CARCINOMA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | Approximate Interval Between Onset and Death   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. Signature and title of certifier<br><br><b>K.A. Dorrance MD</b>   |  | 29c. License number<br><b>D52862</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9-11-00</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>NATIONAL NAVAL MEDICAL CENTER<br/>BETHESDA MD 20889-5600</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>   |  | 32. Registrar's Signature<br>  |  | 33. State Registrar  |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30388

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Velma Fannie Rice</u>   |   | 2. Date of Death<br>Month <u>September</u> Day <u>11</u> Year <u>2000</u>   |  | 3. Time of Death<br><u>2:30 PM</u>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>Northampton Manor Nursing Home</u>  |   | 4b. City, Town, or Location of Death<br><u>Frederick</u>  |  | 4c. County of Death<br><u>Frederick County</u>   |
| Funeral<br>Director  | 5. Social Security Number<br><u>217-28-6586</u>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><u>78</u> Yrs.  | 8. Date of Birth (Month, Day, Year)<br><u>Feb. 4, 1922</u>   | 9. Birthplace (State of Foreign Country)<br><u>Maryland</u>  |
|  | Usual Residence of Decedent  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><u>Maryland</u>  | 10b. County<br><u>Frederick</u>   | 10c. City, Town or Location<br><u>Jefferson</u>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><u>5603 Broadrun Road</u>  |   | 10f. Zip Code<br><u>21755</u>   |  | 10g. Citizen of What Country?<br><u>USA</u>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>7</u> College (1-4 or 5+) <u>self</u>               |  |  |
|  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>homemaker</u>   |   | 16b. Kind of Business/Industry  |  |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><u>Wilmer Wyand Moser</u>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Virgie Elizabeth Stine</u>  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><u>Jerry Rice, husband</u>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>5603 Broadrun Road, Jefferson, Maryland 21755</u> |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Jefferson Methodist Cem.</u>   |  | 20c. Location - City or Town, State<br><u>Jefferson, Maryland</u>  |
|  | 21. Signature of Funeral Service Licen<br><u>[Signature]</u>   |   | 22. Name and Address of Facility<br><u>Keeney &amp; Basford Funeral Home</u><br><u>MO0999 106 East Church Street, Frederick, MD 21701</u>             |  |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>Hepatic Failure</u><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><u>Carcinoma Pancreas</u> |   | Approximate Interval Between Onset and Death<br><u>1 month</u><br><u>6 months</u>   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><u>M</u>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>  |  | 29c. License number<br><u>D 22037</u>   |   | 29d. Date signed (Month, Day, Year)<br><u>9/11/2000</u>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>L KINLAND 610 NINTH AVE BRUNSWICK, MD</u>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><u>SEP 13 2000</u>  |  | 32. Registrar's Signature<br><u>[Signature]</u>   |   |  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 30389

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |   |  |
|---|---|--|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Stuart Hackstaff Sweeney  |  |   |  | 2. Date of Death<br>Month Day Year<br>September 5, 2000  |  |  |  | 3. Time of Death<br>209pm   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Washington Adventist Hospital   |  |   |  | 4b. City, Town, or Location of Death<br>Takoma Park  |  |  |  | 4c. County of Death<br>Montgomery   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>577-20-5296  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>75 Yrs.  |  | If Under 1 Year<br>Months Days   |  | If Under 24 Hrs.<br>Hours Min.  |  |
|   | 8. Date of Birth<br>(Month, Day, Year)<br>Sep 27, 1924  |  | 9. Birthplace (State or Foreign Country)<br>DC  |  | 10a. State<br>MD   |  | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Takoma Park  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>11 Sherman Ave.   |  | 10f. Zip Code<br>20912   |  | 10g. Citizen of What Country?<br>United States                                       |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 43-45  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Attorney   |  | 16b. Kind of Business/Industry<br>Private Practice   |  |  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Algernon T. Sweeney  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Teresa Veneziano  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Sweeney /Wife  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11 Sherman Ave., Takoma Park, MD 20912  |  |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | Date<br>Sep 8 2000   |  | 20c. Location - City or Town, State<br>Beltsville, MD                                |  |   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Beverly L. Helms   |  |   |  | 22. Name and Address of Facility<br>Rapp Funeral & Cremation Services<br>933 Gist Avenue Silver Spring, MD   |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Faryngeal Cancer with metastasis.<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |   |  | Approximate Interval Between Onset and Death<br>2 yrs.   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |   |  |
|   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>MM  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>Stuart Hackstaff Sweeney   |  | 29c. License number<br>D21900  |  | 29d. Date signed (Month, Day, Year)<br>September 5, 2000                             |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 28e) (Type, Print)<br>Stuart H. to 4610 Carroll Ave Takoma Park Md. 20912   |  |   |  |  |  |  |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>SEP 11 2000  |  | 32. Registrar's Signature<br>B. Sparks  |  |  |  |  |  |   |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30390

|  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Darrell Vonray Swayne</b>                         |   |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>8</b> Year <b>2000</b> |  | 3. Time of Death<br><b>9:00 am</b>                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>717 North Belgrade Road</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>             |  | 4c. County of Death<br><b>Montgomery</b>                   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-12-2127</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                         |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 31, 1920</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>DC</b>  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Silver Spring</b>        |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>717 North Belgrade Road</b>   |  | 10f. Zip Code<br><b>20902</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Real Estate Agent</b>   |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry V. Swayne</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jetta Lee</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Virginia C. Swayne / Wife</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>717 North Belgrade Road, Silver Spring, MD 20902</b>                                     |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | 20c. Date<br><b>9/11/00</b>  |  | 20d. Location - City or Town, State<br><b>Silver Spring, MD</b>  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W, Silver Spring, MD 20901</b>   |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Adenocarcinoma of the Prostate</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
| 28e. Pending Investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>021025</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9-12-2000</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert D. Warren, MD 3800 Reservoir Road, Lombardi Cancer Center, Washington, DC</b>  |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |  | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

00 30391

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Wesley T. Starr</b>                                |  |   |  | 2. Date of Death<br>Month <b>Sept.</b> Day <b>7</b> Year <b>2000</b>   |  | 3. Time of Death<br><b>9:40A.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Sligo Creek Nursing Home</b> |  |   |  | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-32-1218</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 14, 1933</b>                      |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>California</b>                                     |  |   |  |  |  |  |  |
| Usual Residence of Decedent  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |   |  | 10b. County<br><b>Prince George's</b>   |  |  | 10c. City, Town or Location<br><b>Adelphi</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>2709 Muskogee Street</b>  |   |  |   | 10f. Zip Code<br><b>20783</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1952-1954</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Pressman</b> |  | 16b. Kind of Business/Industry<br><b>General Conference of Seventh Day Adventist</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Paul V. Starr</b>  |   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth C. Swanson</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Eileen Starr(wife)</b>  |   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b>  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>   |  | Date<br><b>10/3/2000</b>   |  | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>                |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>  |   |  |   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Lewy Body Disease with dementia</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |  |   |  |  |  |  | Approximate Interval Between Onset and Death<br><b>10 yrs.</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  | 28d. Describe how Injury occurred  |  |  |
|  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>Donald V. Borgwardt</b>  |   |  | 29c. License number<br><b>D21900</b>  |  |  | 29d. Date signed (Month, Day, Year)<br><b>September 7, 2000</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Crush Ho 7610 Carroll Ave #280 Takoma Park Md. 20912</b>  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |   |  | 32. Registrar's Signature<br><b>Benita B. Sparks</b>  |  |  |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30392

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FREDA R. SOMMER

2. Date of Death

Month Day Year  
SEPT 11, 2000

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

101-40-0680

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
12/25/1910

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9707 OLD GEORGETOWN ROAD

10f. Zip Code

20814

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

RADIOLOGY TECHNICIAN

16b. Kind of Business/Industry

MEDICAL PRACTICE

17. Father's Name (First, Middle, Last)

ISAK WEINSTEINER

18. Mother's Name (First, Middle, Maiden Surname)

TEEKLA MEIER

19a. Informant's Name/Relationship (Type, Print)

DR. OWEN RENNERT/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10300 BELLS MILL TERRACE, POTOMAC, MARYLAND 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GDNS

Date

SEPT 13, 2000

20c. Location - City or Town, State

FALLS CHURCH, VIRGINIA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

MELANOMA

Approximate Interval Between Onset and Death

17 YEARS

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D37891

29d. Date signed (Month, Day, Year)

SEPT 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMIT RAJVANSI, MD, 121 CONGRESSIONAL LAE, SUITE 409, ROCKVILLE, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

FREDA SOMMER



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30393

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES FRANKLYN SMITH</b>                              |  |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPT. 10 2000</b> |  | 3. Time of Death<br><b>7:35 AM</b>                         |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Montgomery General Hospital</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Olney</b>       |  | 4c. County of Death<br><b>Montgomery</b>                   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-52-4078</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>60</b>                |  | 8. Date of Birth (Month, Day, Year)<br><b>July 23 1940</b> |   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington D.C.</b>                                   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                           |  | 10c. City, Town or Location<br><b>Derwood</b>              |   |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>17809 Teri Drive</b>  |  | 10f. Zip Code<br><b>20855</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>               |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1962-1964</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |  | College (1-4 or 5+) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Supervisor</b>   |  | 16b. Kind of Business/Industry<br><b>Beverage Company</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>James E. Smith</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Virginia Lathan</b>  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn Sue Smith / Wife</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17809 Teri Drive, Derwood, Maryland 20855</b>  |  |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | Date<br><b>9/12/00</b>   |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Muriel H. Barber</b>   |  |  |  | 22. Name and Address of Facility<br><b>Muriel H. Barber Funeral Home<br/>P.O. Box 5038, Laytonsville, Md. 20882</b>  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>three months</b><br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>three months</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>hypertension</b><br><b>diabetes</b><br><b>anemia</b>  |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                 |  |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA  |  | 26. Place of Death (Check only one)<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury of Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br><b>D. H. W.</b>   |  | 29c. License number<br><b>DS2481</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 10, 2000</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David Plotkin M.D. 18111 Prince Philip Dr. Suite 304 Olney MD 20832</b>   |  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>  |  | 32. Registrar's Signature<br><b>B. Sparks</b>  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30394

## Certificate of Death

Reg. No.

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL SHEVIN</b>                          |   |  |   | 2. Date of Death<br>Month <b>September</b> Day <b>5</b> Year <b>2000</b> |  | 3. Time of Death<br><b>0129</b>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>                  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>060-05-7336</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                   | 8. Date of Birth (Month, Day, Year)<br><b>February 23, 1909</b>                                | 9. Birthplace (State or Foreign Country)<br><b>Poland</b>  |  |
|   | Usual Residence of Decedent  |   |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Potomac</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>11215 Seven Locks Road</b>   |  |   |  | 10f. Zip Code<br><b>20854</b>   |  | 10g. Citizen of What Country?<br><b>U. S. A.</b> |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW 2</b><br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+)   |  |   |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Optometrist</b>   |  |  | 16b. Kind of Business/Industry<br><b>Optometry</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Aaron Shevinski</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Shedrovitzky</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Marilyn Shevin-Coetzee - Daughter</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 Seline Court, Potomac, Maryland 20854</b>  |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Judean Memorial Gardens</b>  |  |  | 20c. Location - City or Town, State<br><b>Olney, Maryland</b>                                  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Donald C. Stottmeyer</b>  |  |   |  | 22. Name and Address of Facility<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20854</b>   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>ASARATION PNEUMONIA</b><br>Due to (or as a consequence of):<br><b>MALNUTRITION</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>FRACURE RT. HIP, DEMENTIA</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>FRACURE RT. HIP, DEMENTIA</b>  |  |   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide   |  |   |  | 28a. Date of Injury (Month, Day, Year)<br><b>AUGUST 23 2000</b>   |  | 28b. Time of Injury<br><b>1300 M</b>             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>   |  |   |  | 28d. Describe how injury occurred<br><b>ROLLED OUT OF BED</b>   |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>11215 SEVEN LOCKS RD., POTOMAC MD</b>  |  |   |  |   |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br><b>[Signature] (ONE)</b>   |  | 29c. License number<br><b>015236</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 12, 2000</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHIEF E. MARGOLIS, M.D. (ONE) 11215 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>  |  |   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30395

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ABRAHAM LOUIS SHEITELMAN

2. Date of Death  
Month Day Year  
SEPT 11, 20003. Time of Death  
12:15 PM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

191-30-6925

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

MAY 17, 1938

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13013 BLUHILL COURT

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: VIET-  
NAM13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ANALYST

16b. Kind of Business/Industry

WALL STREET/  
DUNN & BRADSTREET

17. Father's Name (First, Middle, Last)

HIRSH SHEITELMAN

18. Mother's Name (First, Middle, Maiden Surname)

HILDA NEUBAUER

19a. Informant's Name/Relationship (Type, Print)

DAVID SHEITELMAN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13013 BLUHILL COURT, SILVER SPRING, MARYLAND 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CROWNSVILLE CEMETERY

Date  
SEP 15, 2000

20c. Location - City or Town, State

CROWNSVILLE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☐ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Gregory A. Compton MD

29c. License number

DZ4G42

29d. Date signed (Month, Day, Year)

9/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory A. Compton MD 6121 Montrose Rd Rockville, MD 20852

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30396

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |   |   |  |  |  |  |
|---|--|---|--|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Rachelle Violette Shea</b>                              |   |  |  | 2. Date of Death<br>Month Day Year<br><b>September 8, 2000</b> |   |   |  | 3. Time of Death<br><b>6:15 pm</b>                       |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>15101 Interlachen Drive #1024</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |   |   |  | 4c. County of Death<br><b>Montgomery</b>                 |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>018-14-6455</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.               |   | 8. Date of Birth (Month, Day, Year)<br><b>August 10, 1923</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maine</b> |  |  |
|   | Usual Residence of Decedent  |   |  |  |  |   |   |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |  |
| 10e. Street and Number<br><b>15101 Interlachen Drive #1024</b>  |  |   |  | 10f. Zip Code<br><b>20906</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |   |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  |   |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henri Dube</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Yvette Talbot</b>  |  |   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathleen Shea Swendiman/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9609 Dewmar Lane Kensington, Maryland 20895</b>  |  |   |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | 20c. Date<br><b>September 16, 2000</b>   |  | 20d. Location - City or Town, State<br><b>Silver Spring, Maryland</b>                       |   |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00335</b>  |  |   |  | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue<br/>Bethesda, Maryland 20814-3501</b>                           |  |   |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   |   |  |  | Approximate Interval Between Onset and Death   |  |
| Immediate Cause (Final disease or condition resulting in death)   |  |   |  |  |  |   |   |  |  | Sudden   |  |
| Due to (or as a consequence of):  |  |   |  |  |  |   |   |  |  | 6 months   |  |
| Due to (or as a consequence of):  |  |   |  |  |  |   |   |  |  | 2 years  |  |
| Due to (or as a consequence of):  |  |   |  |  |  |   |   |  |  | years  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |  |   |  |  |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hepatic Insufficiency; Anemia; Gout</b>  |  |   |  |  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |  |  |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |   |  |  |  |  |
| 29b. Signature and title of certifier<br><br><b>Oliver J. Lawless M.D.</b>   |  |   |  | 29c. License number<br><b>D25410</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 11, 2000</b>                            |   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Oliver J. Lawless, M.D. 18111 Prince Philip Drive #126 Olney, Maryland 20832</b>   |  |   |  |  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 12 2000</b>   |  | 32. Registrar's Signature<br>   |  |  |  |   |   |  |  |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30397

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TAE POK SHAW

2. Date of Death

SEPTEMBER 9 2000

3. Time of Death

1710

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

315 66 4962

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

49

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 3, 1950

9. Birthplace (State or Foreign Country)

KOREA

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10572 C-2 TWIN RIVERS ROAD

10f. Zip Code

21044

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: ASIAN

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

DRY CLEANING

17. Father's Name (First, Middle, Last)

PONG HWA CHIN

18. Mother's Name (First, Middle, Maiden Surname)

SUN OK KIM

19a. Informant's Name/Relationship (Type, Print)

HOSON HUSKEY (TRUSTEE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15608 STRAUGHN DR LAUREL, MD 20707

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CREMATORY

Date

9-14-00

20c. Location - City or Town, State

BRENTWOOD, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HINES-RINALDI 11800 NEW HAMPSHIRE

AVENUE SILVER SPRING, MD 20904

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. INTRACRANIAL HEMORRHAGE

Due to (or as a consequence of):

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Hye Hye, MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

SEPTEMBER 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30398

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Jack Schwartzberg</b>   |  |   |  | 2. Date of Death<br>Month <b>September</b> Day <b>11</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>11:20A.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Hebrew Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Rockville</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>067-16-1511</b>  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>June 5, 1907</b>   | 9. Birthplace (State or Foreign Country)<br><b>Poland</b>   |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>Montgomery</b>   | 10c. City, Town or Location<br><b>Rockville</b>   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>6121 Montrose Road</b>  |  |   | 10f. Zip Code<br><b>20852</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Metal Designer</b>                    |  | 16b. Kind of Business/Industry<br><b>Merchant</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Isidor Schwartzberg</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ida unk</b>  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara E. Stertz (daughter)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6208 Lone Oak Drive Bethesda, Maryland 20817</b> |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>9/12/2000 Alexandria, Virginia</b>   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Road Beltsville, Maryland 20705</b>                |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia</b><br>Due to (or as a consequence of):  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
|   | 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Vascular Dementia</b>   |  |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| State<br>Registrar                            | 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>DZ4942</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>09/11/2000</b>   |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GREGORY A. COMPTON MD 6121 Montrose Rd Rockville MD</b>   |  |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>  |  | 32. Registrar's Signature<br>   |  |  |  |   |  |





VOID

CERTIFICATE #

30399

SEE

CERTIFICATE #

30773

1908

1908

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30400

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Emma Simmons

2. Date of Death

September 13, 2000

3. Time of Death

6:00 AM

4a. Facility Name (If not Institution, give street and number)

356 Catoctin Avenue

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

214-10-3036

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 3, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

356 Catoctin Avenue

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Raymond

Sweeney

18. Mother's Name (First, Middle, Maiden Surname)

Alice

Rodgers

19a. Informant's Name/Relationship (Type, Print)

Mrs. Sandra S. Dicken, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4397 Amethyst Ct., Middletown, Maryland 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mount Olivet Cemetery, Sept. 15, 2000

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Richard E. Gray

MO0255

22. Name and Address of Facility

Keeney and Basford PA Funeral Home

106 East Church St., Frederick, Md. 21701

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. atherosclerotic heart disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ronald E. Miller

29c. License number

D26499

29d. Date signed (Month, Day, Year)

September 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald E. Miller, M.D., 4 Culwell Drive, Mt. Airy, Maryland 21771

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

Benita B. Apant

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30401

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BARBARA ANN SMITH

2. Date of Death

Month Day Year  
SEPTEMBER 13 2000

3. Time of Death

4:20 PM

4a. Facility Name (If not Institution, give street and number)

SACRED HEART HOSPITAL

4b. City, Town, or Location of Death

CUMBERLAND

4c. County of Death

ALLEGANY

Funeral  
Director

5. Social Security Number

217 42 6450

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 9 1943

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ALLEGANY

10c. City, Town or Location

FROSTBURG

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10601 MOUNTAINSIDE TERRACE

10f. Zip Code

21532

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKER

17. Father's Name (First, Middle, Last)

HARRY W. SMITH

18. Mother's Name (First, Middle, Maiden Surname)

HELEN E. WRIGHT

19a. Informant's Name/Relationship (Type, Print)

CAROL JOHNSON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17024 OLD NATIONAL PIKE FROSTBURG, MD 21532

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

THE CUMBERLAND CREMATORY

Date

8/14/00

20c. Location - City or Town, State

CUMBERLAND, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOWERS FUNERAL HOME, P.A.  
FROSTBURG, MD 2153223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (as a consequence of):

Sepsis

b.

Due to (or as a consequence of):

Pneumonia

c.

Due to (or as a consequence of):

d.

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

3 days

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D12532

29d. Date signed (Month, Day, Year)

9-14-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEORGE M. BREZA 912 SETON DRIVE CUMBERLAND, MD 21502

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

John C. Smith

1972 - 1973

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30402

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Annabell Shreve

2. Date of Death

Month Day Year  
Sept. 13, 2000

3. Time of Death

10:22 am

4a. Facility Name (If not institution, give street and number)

Devlin Manor Nursing Home

4b. City, Town, or Location of Death

Cumberland

4c. County of Death

Allegany

5. Social Security Number

234-46-6756

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Jul 27, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Allegany

10c. City, Town or Location

Cumberland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

212 Seymour Street

10f. Zip Code

21502

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry Twigg

18. Mother's Name (First, Middle, Maiden Surname)

Ethel (Blairdell)

19a. Informant's Name/Relationship (Type, Print)

James W. Shreve, Sr.  
husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

212 Seymour Street; Cumberland MD 21502

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Restlawn Memorial Gard 9/16/ LaVale, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Michael J. Scarpelli*

22. Name and Address of Facility  
Scarpelli Funeral Home, P.A.  
Cumberland, MD 21502

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMERS DEMENTIA

Approximate Interval Between Onset and Death

3 YRS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Dr. Robustiano J. Barrera*

29c. License number

D14865

29d. Date signed (Month, Day, Year)

Sept. 13, 2000

30. Name and address of person who completed causa of death (Item 23e) (Type, Print)

Dr. Robustiano J. Barrera, M.D.; Memorial Hospital, Cumberland, MD 21502

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

*Barrera B Sparks*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1945

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30403

|   |   |   |  |  |  |   |   |  |
|---|---|---|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Pearl Blanche Sites</b>                                  |   |  |  | 2. Date of Death<br>Month <b>08</b> Day <b>31</b> Year <b>00</b> |   | 3. Time of Death<br><b>12:20 am</b>                     |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Moran Manor Health Care Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Westernport</b>       |   | 4c. County of Death<br><b>Allegany</b>                  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>235-80-3640</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>10-2-1919</b> | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>   |
|   | Usual Residence of Decedent   |   |  |  |  |   |   |  |
| 10a. State<br><b>WV</b>   |   | 10b. County<br><b>Hampshire</b>   |  | 10c. City, Town or Location<br><b>Purgitsville</b>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yea <input checked="" type="checkbox"/> No   |
| 10e. Street and Number<br><b>HC 86 Box 153</b>  |   |   |  | 10f. Zip Code<br><b>26852</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yea <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>  |  | 16b. Kind of Business/Industry<br><b>Domestic</b>   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>William B. Smith</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Reel</b>  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Inskeep, Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4548 Minuteman Dr., Rockville, MD 20853</b>  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lahmansville Cemetery</b>  |  | Date<br><b>9-3-00</b>  |  | 20c. Location - City or Town, State<br><b>Lahmansville, WV</b>                              |   |  |
| 21. Signature of Funeral Service Licensee<br><b>Brian L. Smith</b>  |   |   |  | 22. Name and Address of Facility<br><b>Fraleay Funeral Home<br/>145 N. Main St., Moorefield, WV 26836</b>  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |   |   | Approximate interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Intractable Congestive Heart Failure</b>   |   |   |  |  |  |   |   | <b>2 months</b>  |
| Due to (or as a consequence of):  |   |   |  |  |  |   |   |  |
| b. <b>Ischemic Cardiomyopathy</b>   |   |   |  |  |  |   |   | <b>20 years</b>  |
| Due to (or as a consequence of):  |   |   |  |  |  |   |   |  |
| c. <b>Coronary Artery Disease</b>   |   |   |  |  |  |   |   | <b>30 years</b>  |
| Due to (or as a consequence of):  |   |   |  |  |  |   |   |  |
| d.  |   |   |  |  |  |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>  |   |   |  |  |  |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |   |  |  |  |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br>M   |  | 28c. Injury at work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Jesus H. Tan</b>  |   |   |  | 29c. License number<br><b>021244</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9/8/2000</b>                                      |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jesus H. Tan, M.D. 10701 New Georges Creek SW, Frostburg, MD 21532</b>   |   |   |  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 15 2000</b>   |   | 32. Registrar's Signature<br><b>Brian L. Smith</b>  |  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5  
msState  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30404

|   |  |   |  |  |  |  |  |   |
|---|--|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Pauline M. Thorry</b>                   |   |  |  | 2. Date of Death<br>Month <b>Sept</b> Day <b>06</b> Year <b>2000</b> |  | 3. Time of Death<br><b>5:30 am</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>26 Insley Way</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |  | 4c. County of Death<br><b>Baltimore</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>150-16-8633</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>73</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 11, 1927</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b>   |
|   | Usual Residence of Decedent  |   |  |  |  |  |  |   |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>26 Insley Way</b>  |  |   |  | 10f. Zip Code<br><b>21236</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Book Keeper</b>  |  |  | 16b. Kind of Business/Industry<br><b>Atlantic Steamers</b>                                     |   |
| 17. Father's Name (First, Middle, Last)<br><b>Leroy Parry</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Hughes</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Radics / daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>26 Insley Way Baltimore, MD 21236</b>  |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Anatomic Gift Foundation</b>   |  |  | 20c. Location - City or Town, State<br><b>Laurel, MD</b>             |  | 20d. Date<br><b>9-6-00</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>B F O</b>   |  |   |  | 22. Name and Address of Facility<br><b>Anatomic Gift Foundation<br/>13918 Baltimore Ave Laurel, MD 20707</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Metastatic Breast Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>3 yrs</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><b>[Signature] M.D.</b>  |  |   |  | 29c. License number<br><b>45390</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/13/00</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MYO MEDICARD 6830 HOSPITAL DR #206, BALTIMORE, MD 21237</b>  |  |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 15 2000</b>   |  | 32. Registrar's Signature<br><b>[Signature] B. Sparks</b>   |  |  |  |  |  |   |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30405

|   |   |                                 |  |  |  |   |  |   |
|---|---|---------------------------------|--|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>John B. Thomas, Jr.</b>                              |                                 |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>6</b> Year <b>2000</b> |   | 3. Time of Death<br><b>8:00 PM</b>       |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Carriage Hill Nursing Home</b> |                                 |  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>                  |   | 4c. County of Death<br><b>Montgomery</b> |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>400-54-1516</b>   | 6. Sex<br><b>1</b> M <b>2</b> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 24, 1914</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Kentucky</b>             |
|   | Usual Residence of Decedent   |                                 |  |  | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Montgomery</b>         |   |
| 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   |                                 |  | 10e. Street and Number<br><b>2013 Forest Dale Drive</b>  |  | 10f. Zip Code<br><b>20903</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                             |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |   |                                 |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>  |   |                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Navy Commander</b>   |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>John B. Thomas</b>  |   |                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Flora Stallard</b>   |  |   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John M. Thomas / Son</b>   |   |                                 |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>103 Walden Street, Cambridge, Massachusetts 02140</b>                        |  |   |  |   |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |   |                                 |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Crematory</b>  |  | 20c. Date<br><b>09/10/00</b>  |  | 20d. Location - City or Town, State<br><b>Brentwood, Maryland</b>       |
| 21. Decedent's Usual Residence<br><b>Silver Spring, Maryland</b>  |   |                                 |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home</b><br><b>11800 New Hampshire Avenue</b><br><b>Silver Spring, Maryland 20904</b>                               |  |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aspiration pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Dehydration</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |                                 |  | Approximate Interval Between Onset and Death   |  |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                                 |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown  |  |   |  |   |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |   |                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No  |  |   |  |   |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   |                                 |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |  |   |
| 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending investigation <b>6</b> Could not be determined   |   |                                 |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                        |
| 28d. Describe how injury occurred   |   |                                 |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                                 |  | 29b. Signature and title of certifier<br><b>Susan Voss, MD</b>   |  |   |  |   |
| 29c. License number<br><b>D28267</b>  |   |                                 |  | 29d. Date signed (Month, Day, Year)<br><b>September 6, 2000</b>  |  |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Susan Voss, MD 11402 Allview Drive, Beltsville, Maryland 20705</b>   |   |                                 |  | 31. Date filed (Month, Day, Year)<br><b>SEP 11 2000</b>  |  |   |  |   |
| 32. Registrar's Signature<br><b>B. Sparks</b>   |   |                                 |  | 33. Date of Death<br><b>SEP 11 2000</b>  |  |   |  |   |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 30406

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ellie M. Taylor

2. Date of Death

September 4, 2000

3. Time of Death

11:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Transitional Care Center

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

422-38-9188

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr. 25, 1908

9. Birthplace (State or Foreign Country)

Alabama

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

13218 Holdridge Road

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Matthew Palmer

18. Mother's Name (First, Middle, Maiden Surname)

Lucindy Hagler

19a. Informant's Name/Relationship (Type, Print)

Silver B. West / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13218 Holdridge Road, Wheaton, Maryland 20906

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rock Creek Cemetery

Date

09/08/00

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 2090423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Arrhythmia

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ascites

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D42578

29d. Date signed (Month, Day, Year)

SEPTEMBER 04, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)


G. CITABIANI, 11119 Rockwood Pike #401, Rockwood West

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30407

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT TALBOTT

2. Date of Death

Month Day Year  
September 10, 2000

3. Time of Death

1:00pm

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Nursing &amp; Rehab. Ctr.

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-07-5633

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 2, 1908

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18700 Walkers Choice Rd. #418

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Maintenance Engineer

16b. Kind of Business/Industry

Building Maintenance

17. Father's Name (First, Middle, Last)

John William Talbott

18. Mother's Name (First, Middle, Maiden Surname)

Lula Fletcher

19a. Informant's Name/Relationship (Type, Print)

Betty L. Talbott (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18700 Walkers Choice Rd. #418 Montgomery Village, Md. 20886

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

Sept. 13  
2000

20c. Location - City or Town, State

Rockville, Md.

21. Signature of Funeral Service Licensee

Curtis E. Day

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr. Gaithersburg, Md. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. Arteriosclerotic Cardiovascular Disease

Years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

c. Advanced Age

Years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

Hypertension

Cerebro Vascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Kevin M. Gil M.D.

29c. License number

D35192

29d. Date signed (Month, Day, Year)

September 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Kevin M. Gil M.D. 14816 Physicians Lane #253 Rockville, Md. 20850

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30408

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN THOMPSON

2. Date of Death

Month Day Year  
SEPTEMBER 10, 2000 8:42 A.M.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

264-36-8238

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 29, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

315 Adam Road

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

baker

16b. Kind of Business/Industry

grocery store

17. Father's Name (First, Middle, Last)

Joseph Charles O'Neill

18. Mother's Name (First, Middle, Maiden Summa)

Dorothy Mae Lintz

19a. Informant's Name/Relationship (Type, Print)

John W. Thompson, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

315 Adam Road, Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Memorial Gard.

Date

9/13/

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

▶ *[Signature]*

22. Name and Address of Facility

MO0255

Keeney and Basford Funeral Home

106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular fibrillation

Due to (or as a consequence of):

b. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minute years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

colds  
Cor Pulmonale  
Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ *[Signature]*

29c. License number

D 26516

29d. Date signed (Month, Day, Year)

SEPTEMBER 11, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Allen J. Gilson MD

1475 TANEY AVE FRED

MD 21702

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

▶ *[Signature]*

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30409

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Earl Tracey

2. Date of Death

Month Day Year  
Sept. 16, 2000

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

21429 N. Ruhl Road

4b. City, Town, or Location of Death

Freeland

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

163-24-7698

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 8, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

White Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3002 Anderson Road

10f. Zip Code

21161

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Machinist

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Vernon Tracey

18. Mother's Name (First, Middle, Maiden Surname)

Katie Tracey

19a. Informant's Name/Relationship (Type, Print)

Joan E. Chilcoat, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3002 Anderson Rd., White Hall, MD 21161

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
Middletown Cemetery

Date

Sept. 19, 2000

20c. Location - City or Town, State

Freeland, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.  
24 Second St., New Freedom, PA 17349

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute myocardial infarction*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Parkinson's Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)*Daughter's Home*

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D18822

29d. Date signed (Month, Day, Year)

9/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HABERSAT 41 Mt Carmel Rd Parkton, MD 21120

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





McDonald Kelly Umberger, Jr.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a, 27, 28a, b, c, d, e, f per me G787 9/27/00 yf

## Certificate of Death

Reg. No.

00 30410

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

McDonald Kelly Umberger, Jr.

2. Date of Death

Month Day Year  
September 12, 2000 6:30 A.M.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

436 West Deer Park Road

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

213-44-6980

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 20, 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

436 West Deer Park Road

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Land Surveyor

16b. Kind of Business/Industry

Surveying Company

17. Father's Name (First, Middle, Last)

McDonald Kelly Umberger, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Helen Swann

19a. Informant's Name/Relationship (Type, Print)

Jeffrey S. Umberger (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20300 Frederick Road, Germantown, MD 20876

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Forest Oak Cemetery

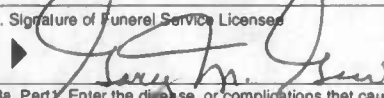
Date

9/16/00

20c. Location - City or Town, State

Gaithersburg, Maryland

21. Signature of Funeral Service Licensed



22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☒ Other (Specify) at scene

27. Manner of Death

☐ Natural ☐ Accident  
☐ Suicide ☐ Homicide☐ Pending investigation  
☒ Could not be determined

28a. Date of Injury

(Month, Day, Year)

found: 9/12/00

28b. Time of Injury

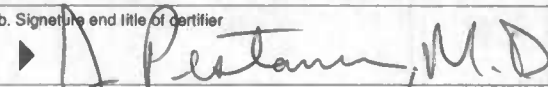
found: 6:00

M

28c. Injury at Work?

☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)  
found at home28d. Describe how injury occurred  
unknown28f. Location (Street and Number or Rural Route Number,  
City or Town, State) 436 W. Deer Park Road,  
Gaithersburg, Md.29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

September 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30411

|   |  |  |   |  |   |  |   |  |
|---|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Melvin Uhl   |  |   |  | 2. Date of Death<br>Month Day Year<br>Sept 12 2000  |  | 3. Time of Death<br>7:56PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Memorial Hospital  |  |   |  | 4b. City, Town, or Location of Death<br>Cumberland  |  | 4c. County of Death<br>Allegany   |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-20-5997   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>74 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>December 6, 1925   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>MD  |  | 10b. County<br>Allegany   |  | 10c. City, Town or Location<br>LaVale   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|   | 10e. Street and Number<br>200 South First St.  |  |   |  | 10f. Zip Code<br>21502  |  | 10g. Citizen of What Country?<br>United States  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3 College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesman   |  | 16b. Kind of Business/Industry<br>Automobile  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Mervin Uhl, Sr.   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katherine (Gearry)   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Greg Uhl / son   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>35 Johns Lane LaVale, MD 21502   |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rocky Gap Veterans  |  | 20c. Location - City or Town, State<br>9/15/2000 Cumberland, MD   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>Merritt-Adams Funeral Home, P.A. 404 Decatur St<br>Cumberland, MD 21502   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death) Mulptle trauma with complications<br>a. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |   |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |  |   |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br>9/9/2000  |  | 28b. Time of Injury<br>6:18P M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Parking lot restaurant   |  |   |  | 28d. Describe how injury occurred<br>passanger in auto accident   |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>1118 National Hwy LaVale MD  |  |   |  |   |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |   |  |
| State<br>Registrar  | 29b. Signature and title of certifier<br>Dpty Med Ex   |  |   |  | 29c. License number<br>D 09157  |  | 29d. Date signed (Month, Day, Year)<br>Sept 12 2000   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Paul Snow, M.D. 124 w 3rd st Cumberland Md 21502   |  |   |  |   |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>SEP 14 2000   |  |   |  | 32. Registrar's Signature<br>   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Journal of the ... 1891

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30412

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
|---|---|---|---|--|--|--|--|--|---|----|---------------------|--|----|-------------------|----|--|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Vladimir A. Vishnevsky  |   |   |  | 2. Date of Death<br>Month Day Year<br>Sept. 8, 2000  |  | 3. Time of Death<br>2:30pm   |  |   |    |                     |  |    |                   |    |  |    |
|   | 4a. Facility Name (If not institution, give street and number)<br>Washington Adventist Hospital   |   |   |  | 4b. City, Town, or Location of Death<br>Takoma Park  |  | 4c. County of Death<br>Montgomery  |  |   |    |                     |  |    |                   |    |  |    |
| Funeral<br>Director   | 5. Social Security Number<br>602-50-6757  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>80 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month Day Year<br>July 3, 1920   |  | 9. Birthplace (State or Foreign Country)<br>Russia |   |    |                     |  |    |                   |    |  |    |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
| To Be Completed by Funeral Director   | 10a. State<br>Md  | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Takoma Park   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |    |                     |  |    |                   |    |  |    |
|   | 10e. Street and Number<br>7513 Maple Avenue #603  |   |   |  | 10f. Zip Code<br>20912   |  | 10g. Citizen of What Country?<br>USA   |  |   |    |                     |  |    |                   |    |  |    |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |   |    |                     |  |    |                   |    |  |    |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4   |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Civil engineer                    |  |  | 16b. Kind of Business/Industry<br>Construction   |  |  |   |    |                     |  |    |                   |    |  |    |
|   | 17. Father's Name (First, Middle, Last)<br>Alexander Vishnevsky   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Barbara Petrovsky   |  |  |  |   |    |                     |  |    |                   |    |  |    |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Marina Vishnevsky/Wife  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7513 Maple Ave. #603 Takoma Park, Md 20912  |  |  |  |   |    |                     |  |    |                   |    |  |    |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rock Creek Cemetery   |  | Date<br>9/12/00  |  | 20c. Location - City or Town, State<br>Wash.D.C.   |  |   |    |                     |  |    |                   |    |  |    |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>PHILIP D. RINALDI FUNERAL SERVICE<br>11818 New Hampshire Ave. Silver Spring, Md  |  |  |  |   |    |                     |  |    |                   |    |  |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Respiratory failure</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/>           5 Days<br/><br/>           3 months         </td> </tr> <tr> <td>b.</td> <td>Carcinoma of Lung</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Respiratory failure | Approximate Interval Between Onset and Death<br><br>5 Days<br><br>3 months | b. | Carcinoma of Lung | c. |  | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a.  | Respiratory failure   | Approximate Interval Between Onset and Death<br><br>5 Days<br><br>3 months  |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
|   | b.  | Carcinoma of Lung   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
|   | c.  |   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
|   | d.  |   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |   |    |                     |  |    |                   |    |  |    |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |    |                     |  |    |                   |    |  |    |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |    |                     |  |    |                   |    |  |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |    |                     |  |    |                   |    |  |    |
|   |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |    |                     |  |    |                   |    |  |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
| 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br>D 18895   |  | 29d. Date signed (Month, Day, Year)<br>September 9, 2000   |  |  |   |    |                     |  |    |                   |    |  |    |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br>MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD 20912  |   |   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |
| 31. Date filed (Month, Day, Year)<br>SEP 11 2000  |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |   |    |                     |  |    |                   |    |  |    |





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30413

|   |  |   |   |   |  |  |  |  |
|---|--|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>CHARLES E. WOOD  |   |   |   | 2. Date of Death<br>Month Day Year<br>September 12, 2000   |  | 3. Time of Death<br>6:45 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>17809 Dominion Drive   |   |   |   | 4b. City, Town, or Location of Death<br>Sandy Spring   |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-30-2487   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br>Feb. 6 1933  | 9. Birthplace (State or Foreign Country)<br>Maryland   |
|   | Usual Residence of Decedent  |   |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   |   | 10b. County<br>Montgomery   |   | 10c. City, Town or Location<br>Sandy Spring  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|   | 10e. Street and Number<br>17809 Dominion Drive   |   |   |   | 10f. Zip Code<br>20860   |  | 10g. Citizen of What Country?<br>United States   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1953-1955 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Vice President  |  | 16b. Kind of Business/Industry<br>Commercial Banking   |  |
|   | 17. Father's Name (First, Middle, Last)<br>Delmas P. Wood Sr.  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth E. Easton   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Anneliese R. Wood / Wife   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>17809 Dominion Drive, Sandy Spring, Md. 20860   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Friends Cemetery  |   | Data<br>9/15/00  |  | 20c. Location - City or Town, State<br>Sandy Spring, Md.   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Muriel H. Barber</i>   |   |   |   | 22. Name and Address of Facility<br>Muriel H. Barber Funeral Home<br>P.O. Box 5038, Laytonsville, Maryland 20882   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Respiratory Failure</i><br>Due to (or as a consequence of):<br>b. <i>Metastatic Carcinoma of Stomach</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |   |   |   |  |  |  | Approximate Interval Between Onset and Death<br>24 hours   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Adult onset Diabetes Mellitus</i>   |   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Daniel L. Anderson MD</i>   |   | 29c. License number<br>D03592             |  | 29d. Date signed (Month, Day, Year)<br>September 13, 2000                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DANIEL L. ANDERSON, MD 2901 Olney - Sandy Spring Pkwy Olney, Maryland 20832   |  |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 14 2000  |  | 32. Registrar's Signature<br><i>B. Sparks</i>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30414

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas E. Wall

2. Date of Death

Month  
9Day  
6Year  
2000

3. Time of Death

8:05 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

5. Social Security Number

172-40-7753

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 14, 1948

9. Birthplace (State or Foreign Country)

Mahanoy City, PA

Usual Residence of Decedent

10a. State

PA

10b. County

Schuylkill

10c. City, Town or Location

Mahanoy City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10 W. Center Street

10f. Zip Code

17948

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Labor

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

William Wall

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Rhubright

19a. Informant's Name/Relationship (Type, Print)

Evelyn Wall - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 W. Center St. Mahanoy City, PA 17948

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

9/8/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, VA 22310

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hepatitis C Cirrhosis

3 years

Due to (or as a consequence of):

b. Alcoholic Cirrhosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Handrens MD

29c. License number

P13356

29d. Date signed (Month, Day, Year)

September 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEATHER ANDRENS 17 South Greene Street Baltimore MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30415

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHERYLL A. WALKER

2. Date of Death

Month Day Year  
SEPT. 8, 2000

3. Time of Death

10:15 PM

4a. Facility Name (If not institution, give street and number)

Randolph Hills Nursing Home

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-70-4574

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr. 5, 1950

9. Birthplace (State or Foreign Country)

Wash. DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12517 Rosebud Drive

10f. Zip Code

20853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Artist

16b. Kind of Business/Industry

Lon Mill  
Industries

17. Father's Name (First, Middle, Last)

James A. Walker

18. Mother's Name (First, Middle, Maiden Surname)

Jean Comissiong

19a. Informant's Name/Relationship (Type, Print)

James A. Walker (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12517 Rosebud Dr., Rockville, MD 20853

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory

Date

9/11/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 20850

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Lupus Erythematosus; Hypoxemia; Brain

Damage

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D08944

29d. Date signed (Month, Day, Year)

Sept. 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin C Shargel, M.D. 3720 Farragut Ave., Kensington, MD 20895

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 30416

|   |  |  |   |                                |  |  |  |
|---|--|--|---|--------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret L. Westfall</b>  |  |   |                                | 2. Date of Death<br>Month <b>Sep</b> 8, 2000 Year <b>2000</b>  |  | 3. Time of Death<br><b>11:00pm</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>14021 Mt. Savage Road</b>   |  |   |                                | 4b. City, Town, or Location of Death<br><b>Mt. Savage</b>  |  | 4c. County of Death<br><b>Allegany</b>   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-10-5093</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Dec 18, 1908</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |
|   | Usual Residence of Decedent  |  |   |                                |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  | 10b. County<br><b>Allegany</b>   | 10c. City, Town or Location<br><b>Cumberland</b>  |                                |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>112 West Elder Street</b>   |  |   | 10f. Zip Code<br><b>21502</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |                                | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Charles Starnes</b>  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Viola (Duckworth)</b>  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dee Ann Stotler</b>   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>HCR 62 Box 29B; Great Cacapon, WV 25422</b>  |  |  |
|   | 20a. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Queens Point Cemetery</b>   |  | 20b. Date<br><b>9/13/</b>   |                                | 20c. Location - City or Town, State<br><b>Keyser, WV</b>   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Nicholas J. Scarpelli</b>  |  | 22. Name and Address of Facility<br><b>Scarpelli Funeral Home P.A. Cumberland, Maryland 21502</b>   |                                |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Esophageal Cancer (advanced)</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |                                |  |  | Approximate Interval Between Onset and Death<br><b>9 months</b>  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Home of Granddaughter</b> |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                |  |  |  |
|   | 29b. Signature and title of certifier<br><b>[Signature]</b>  |  | 29c. License number<br><b>D23371</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>Sep 12, 2000</b>   |  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Qamar U Zaman M.D. 625 Kent Avenue Cumberland MD 21502</b>  |  |   |                                |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |                                |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Handwritten text, possibly a signature or initials.

0005 61432

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30417

|  |   |   |  |  |   |   |  |  |
|--|---|---|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James R. Whiteman</b>  |   |  |  | 2. Date of Death<br>Month <b>9</b> Day <b>11</b> Year <b>2000</b> |   | 3. Time of Death<br><b>7:40 am</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Memorial Hospital &amp; Medical Center</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cumberland</b>         |   | 4c. County of Death<br><b>Allegany</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>236-76-0890</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.   | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 25, 1951</b>                                     | 9. Birthplace (State or Foreign Country)<br><b>WV</b>  |
|  | Usual Residence of Decedent   |   |  |  |   |   |  |  |
| 10a. State<br><b>WV</b>  |   | 10b. County<br><b>Mineral</b>   |  | 10c. City, Town or Location<br><b>Piedmont</b>   |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>40 Second Street</b>  |   |   |  | 10f. Zip Code<br><b>26750</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ret. laborer</b>   |   |   | 16b. Kind of Business/Industry<br><b>Westvaco Corp.</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Junior Whiteman</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Adelaide (James)</b>   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Ann Whiteman wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>40 Second Street; Piedmont, WV 26750</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Peter's Cemetery</b>  |   | 20c. Location - City or Town, State<br><b>9/14/ Westernport, MD</b>                         |  |  |
| 21. Signature of funeral licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Fredlock Funeral Home<br/>Piedmont, WV 26750</b>  |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Refractory head and neck cancer</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |   |   |  |  |   |   |  | Approximate Interval Between Onset and Death<br><b>7 months</b>  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D0023371</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>September 11, 2000</b>                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Qamar Zaman Johnson Heights Med Bldg 625 Kent Ave Ste 102 Cumberland, MD 21502</b>  |   |   |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 15 2000</b>  |   | 32. Registrar's Signature<br>   |  |  |   |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

JAMES WHITEMAN 236-76-0890

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

*Handwritten signature*

0005 6 1 932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30418

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ERNEST VINCENT YANCEY

2. Date of Death

Month Day Year  
SEP 8 2000

3. Time of Death

12:41 PM

4a. Facility Name (If not Institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

350-22-3694

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 3, 1931

9. Birthplace (State or Foreign Country)

Tenn.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7501 Democracy Blvd.

10f. Zip Code

20817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1954-58

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Foreign Economic Development

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

John Yancey

18. Mother's Name (First, Middle, Maiden Surname)

Dinelli Inez

19a. Informant's Name/Relationship (Type, Print)

Todd Jude Yancey/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30 W. 63rd St., #7D New York, New York 10023

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

Sept. 19 2000

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
2222 Wisconsin Ave., N.W.  
Washington, D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL CELL CARCINOMA

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-0051320

29d. Date signed (Month, Day, Year)

SEPTEMBER 11, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

J.S. YAMAMOTO, LT, MC, USNR

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30419  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Ruth Ashe

2. Date of Death  
Month Day Year  
September 25, 2000 12:00 p.m.

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

215-18-9564

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 1, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

2147 Greythorn Rd.

10f. Zip Code

21220

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Dennis Knox Touhey

18. Mother's Name (First, Middle, Maiden Surname)

Margaret McDonough

19a. Informant's Name/Relationship (Type, Print)

George Bateman/son-in-law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

402 Fox Chapel Dr. Timonium, MD 21093

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Prospect Hill Cemetery

Date

9/28/00

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

John D. Mitchell IV

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Rd.  
Baltimore, MD 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Ruptured thoracic aortic aneurysm

Minutes

Due to (or as a consequence of):

b. Atherosclerosis

Years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Steven H. Pearlman M.D.

29c. License number

D30206

29d. Date signed (Month, Day, Year)

9/26/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Steven H. Pearlman M.D. GBMC, 6701 N. Charles St., Baltimore, MD 21204

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

Benita A. Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Ashe, Catherine

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend 31 per dvr G787 9/27/00 yf

## Certificate of Death

Reg. No.

00 30420

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grace Phipps Allen

2. Date of Death

Month Day Year  
Sept. 22, 2000

3. Time of Death

11:00 P

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Bayview Medical Ctr.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-26-9978

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan. 20, 1913

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6908 German Hill Road

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jospeh Phipps

18. Mother's Name (First, Middle, Maiden Surname)

Grace Tarbert

19a. Informant's Name/Relationship (Type, Print)

Patricia Sikorski/G-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

202 Woodland Ave., Apt. B3, Balyo. Md 21222

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Balto-Wash. Crematory

Date

9-27-00

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

Robert Wade

22. Name and Address of Facility

Bradley-Ashton-Matthews Funeral Home, Inc.  
2134 Willow Spring Rd., Balto., Md. 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Intervention  
Due to (or as a consequence of):b. Coronary Artery Disease  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Melvin

29c. License number

9-27924

29d. Date signed (Month, Day, Year)

9/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Melvin Melvin M.D. - 3509 Eastern Avenue

State  
Registrar

31. Date filed (Month, Day, Year)

9/25/00

32. Registrar's Signature

SEP 27 2000

Benita B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30421

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles George Airey, Jr.

2. Date of Death  
Month Day Year  
September 24 2000

3. Time of Death  
6:25 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number  
213-07-8544

6. Sex  
M ☒ F ☐

7. Age (In yrs. last birthday)  
83 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
July 29, 1917

9. Birthplace (State or Foreign  
Country)  
Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County  
Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

58 Mavista Avenue

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
10 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Charles G. Airey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Grace Hammel

19a. Informant's Name/Relationship (Type, Print)

Mrs. Margaret J. Airey (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

58 Mavista Avenue Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holly Hill Mem. Gdns. 9/27/2000

Date

20c. Location - City or Town, State

Middle River, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Colon Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1997-2000

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

RD 203331

29d. Date signed (Month, Day, Year)

9/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. McDowell MD. 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

ORIGINAL

Airey, Charles G.  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30422

|   |   |  |                                 |  |   |   |  |  |
|---|---|--|---------------------------------|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CHARLES ALLEN</b>                        |  |                                 |  | 2. Date of Death<br>Month <b>SEP</b> Day <b>24</b> Year <b>2000</b> |   | 3. Time of Death<br><b>1442</b>                              |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>MERCY HOSPITAL</b> |  |                                 |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>            |   | 4c. County of Death<br><b>N/A</b>                            |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-10-5257</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                    |   | 8. Date of Birth (Month, Day, Year)<br><b>April 28, 1920</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                             |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>              |  |
| 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   | 10e. Street and Number<br><b>124 W. Franklin St.</b>   |                                 | 10f. Zip Code<br><b>21201</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4or 5+)  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>   |                                 | 16b. Kind of Business/Industry<br><b>Hospital</b>  |   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Allen Sr.</b>   |   |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josephine Northing</b>   |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print) (Friend)<br><b>Mrs. Beulah Addison</b>   |   |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>301 McMechen St. Apt. 819 Balto. Md. 21217</b> |   |   |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Piney Grove Freewill Bapt. Ch. Cem.</b>   |                                 | 20c. Location - City or Town, State<br><b>9/29/2000 Fayetteville, N.C.</b>   |   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>  |   |  |                                 | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>                                     |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Staph sepsis</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   | Approximate interval Between Onset and Death<br><b>5d</b>  |                                 |  |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |                                 |  |   | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |  |  |
|   |   |  |                                 |  |   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |
|   |   |  |                                 |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |                                 |  |   |   |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |   | 28a. Date of Injury (Month, Day, Year)   |                                 | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  |  |
|   |   | 28d. Describe how injury occurred  |                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br><b>2</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |                                 |  |   |   |  |  |
| 29b. Signature and title of certifier<br><b>Joseph Costa MD</b>   |   |  |                                 |  |   |   |  |  |
| 29c. License number<br><b>D42634</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>SEP 24 2000</b>  |                                 |  |   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH COSTA 301 ST PAUL PLACE BALTIMORE MD 21202</b>  |   |  |                                 |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>   |                                 |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 30423

|  |  |   |   |  |  |   |   |   |  |  |
|--|--|---|---|--|--|---|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Dorothy V. Burgess</i>  |   |   |  |  | 2. Date of Death<br>Month Day Year<br><i>Sept. 24, 2000</i>   |   |   | 3. Time of Death<br><i>12:01 pm</i>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Continuing Care</i>   |   |   |  |  | 4b. City, Town, or Location of Death<br><i>Sykesville</i>   |   |   | 4c. County of Death<br><i>Carroll</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>213-05-2822</i>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>86</i> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><i>July 13, 1914</i>                                 |   | 9. Birthplace (State or Foreign)<br><i>Maryland</i>  |  |
|  | Usual Residence of Decedent  |   |   |  |  |   |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><i>MD</i>  |   | 10b. County<br><i>Carroll</i>   |  | 10c. City, Town or Location<br><i>Westminster</i>  |   |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br><i>2395 Moreau Drive</i>   |   |   |  | 10f. Zip Code<br><i>21158</i>  |   | 10g. Citizen of What Country?<br><i>U.S.A.</i>  |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i> <i>College (1-4 or 5+)</i>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Homemaker</i>  |   |   | 16b. Kind of Business/Industry<br><i>Own Home</i>                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Daniel Pembroke Trogler</i>  |   |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Clementine Pauline Smith</i>  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Melvin Burgess - Son</i>  |   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2395 Moreau Drive Westminster, Maryland 21158</i> |   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Meadowridge Memorial Pk</i>  |  |  | Date<br><i>9/27/00</i>  |   | 20c. Location - City or Town, State<br><i>Elkridge, Maryland</i>        |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |  |  | 22. Name and Address of Facility<br><i>Gary L. Kaufman Funeral Home, Inc.<br/>7250 Washington Blvd. Elkridge, MD 21075</i>                            |   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Cerebral Vascular Accident</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>2 wks</i>  |   |   |  |  |   |   |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |   |  |  |   |   |   |  |  |
| State<br>Registrar   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  |  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |   |   |  |  |
|  | 29b. Signature and title of certifier<br><i>Robert J. Moss, MD</i>   |   |   |  |  | 29c. License number<br><i>032882</i>  |   | 29d. Date signed (Month, Day, Year)<br><i>9/25/00</i>                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Robert L. Moss 114 Business Center Dr. Reisterstown, MD 21136</i> |  |   |   |  |  |   |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>SEP 27 2000</i>  |  | 32. Registrar's Signature<br><i>[Signature]</i> |   |  |  |   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM#20B PER F.H. State of Maryland / Department of Health and Mental Hygiene

G787 10-4-00 WB

## Certificate of Death

Reg. No.

00 30424

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PEARLINA BERNARD

2. Date of Death

Month Day Year  
SEPTEMBER 23, 2000

3. Time of Death

7:15 PM

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

215-28-3907

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6-17-1932

9. Birthplace (State or Foreign Country)

SC.

Usual Residence of Decedent

10a. State

MD.

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3615 TEMPLAR RD.

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
-12-College (1-4 or 5+)  
-4-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DIRECTOR

16b. Kind of Business/Industry

SOCIAL SECURITY

17. Father's Name (First, Middle, Last)

ADDISON McKNIGHT

18. Mother's Name (First, Middle, Maiden Surname)

JOSEPHINE PATTON

19a. Informant's Name/Relationship (Type, Print)

JAMES E. BERNARD JR. (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3615 TEMPLAR RD. RANDALLSTOWN, MARYLAND 21133

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS MEMORIAL PARK

Date

9-28-2000 BALTIMORE, MARYLAND

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Jonathan D. Hirsner

22. Name and Address of Facility

PHILLIPS FUNERAL HOME, P.A.  
7121-27 N. MONROE ST. BALTIMORE, MARYLAND 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Clifford Faber, MD

29c. License number

024970

29d. Date signed (Month, Day, Year)

SEPTEMBER 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CLIFFORD FABER, MD - 5401 OLD COURT ROAD, RANDALLSTOWN, MARYLAND

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

B. Sparks

21133

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30425

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |
|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>RAY BAUGHER</b>  |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 24, 2000</b>   |  | 3. Time of Death<br><b>4:15 PM</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>BAYVIEW HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-16-6303</b>   | 6. Sex<br><b>1 M 2 F</b>   | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>October 19, 1922</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |
|  | 10c. City, Town or Location<br><b>Dundalk</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  | 10e. Street and Number<br><b>1904 Adams Road</b>  |  | 10f. Zip Code<br><b>21222</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b> If Yes, Give Year or Dates: <b>WWII</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b> Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12 Years</b>                                  |  |  |
| To Be Completed by Physician/Medical Examiner  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b>  |  | 16b. Kind of Business/Industry<br><b>Steel Industry</b>   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ernest G. Baugher</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruby Newton</b>   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Charles A. Baugher (Son)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1904 Adams Road Dundalk, Maryland 21222</b> |  |  |
|  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | 20c. Location - City or Town, State<br><b>9/24/2000 Towson, Maryland</b>   |
|  | 21. Signature of <b>ERNEST BAUGHER</b>  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222</b>                       |  |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASPIRATION PNEUMONIA</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>ONE DAY</b>   |
|  | Due to (or as a consequence of):<br><b>LUNG CANCER</b>  |  |   |  | <b>TWO YEARS</b>   |
|  | Due to (or as a consequence of):  |  |   |  |  |
|  | Due to (or as a consequence of):  |  |   |  |  |
|  | Due to (or as a consequence of):  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>METASTASES TO BRAIN</b>   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>   |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |   |  |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>  |   | 28a. Date of Injury (Month, Day Year)<br><b>M</b>  |   | 28b. Time of Injury<br><b>1 Yes 2 No</b>                         |  |
| 28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred  |   |  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |   |  |   |  |  |
| 29b. Signature and title of certifier<br><b>MD. - INTERN</b>   |   | 29c. License number<br><b>21022</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 24, 2000</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ERIC SANSTAD, 4940 EASTERN AVENUE, BALTIMORE, MARYLAND</b>  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |   | 32. Registrar's Signature<br><b>Beverly Sparks</b>   |   |  |  |

ORIGINAL



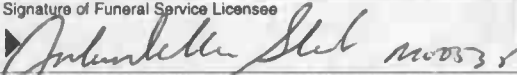
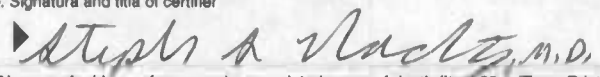

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30426

|  |   |  |  |  |   |   |  |  |
|--|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Shirley Reinhardt -Byrd</b>                          |  |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 20, 2000</b> |   | 3. Time of Death<br><b>13:09 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3438 EAST UNIVERSITY PLACE</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>        |   | 4c. County of Death<br><b>Baltimore City</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215284556</b>   |  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>70 Yrs.</b>                |   | 6. Data of Birth (Month, Day, Year)<br><b>Sep 4, 1930</b>                                      |  |
|  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore City</b>            |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b></b>  |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed</b>  |   | 16b. Kind of Business/Industry<br><b>Retail Store</b>                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward L. Reinhardt</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hertha Emma Louise Dove</b>  |   |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Robert E. Reinhardt</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7607 Gaither Road Sykesville, Maryland 21784</b>   |   |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                       |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |  |  | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>   |   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. </b><br>Dua to (or as a consequence of):<br><br><b>c. </b><br>Dua to (or as a consequence of):<br><br><b>d. </b> |   |  |  | Approximate Interval Between Onset and Death   |   |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |  |  |
| 24a. Was an autopsy performed?<br><b>Limited</b>   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>SCENE</b> |   |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |  |  | 28a. Date of Injury (Month, Day Year)<br><b></b>   |   | 28b. Time of Injury<br><b>M</b>   |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  | 28d. Describe how injury occurred<br><b></b>   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b> |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.   |   |  |  | 29b. Signature and title of certifier<br><br><b>O.C.M.E.</b>  |   |   |  |  |
| 29c. License number<br><b></b>   |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 21, 2000</b>   |   |   |  |  |
| 30. Name and address of person who completed cause of death (If 23a (Type, Print)<br><b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>   |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |   |  |  | 32. Registrar's Signature<br>   |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30427

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|   |  |   |   |  |  |
|---|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>ALICE M BLOCH</b>  |  | 2. Date of Death<br>Month Day Year<br><b>SEPT 22 2000</b>   |   | 3. Time of Death<br><b>2:05PM</b>  |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>FUTURECARE-CHERRYWOOD NURSING HOME</b>   |  |   | 4b. City, Town, or Location of Death<br><b>REISTERSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>  |
| 5. Social Security Number<br><b>215-30-0629</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 26, 1908</b>  |
| 9. Birthplace (State or Foreign Country)<br><b>GERMANY</b>  |  |   |   |  |  |
| Usual Residence of Decedent   |  |   |   |  |  |
| 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTIMORE</b>  | 10c. City, Town or Location<br><b>REISTERSTOWN</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>12020 REISTERSTOWN ROAD</b>  |  | 10f. Zip Code<br><b>21136</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br><b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |   |  |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SEAMSTRESS</b>  |  | 16b. Kind of Business/Industry<br><b>HAT COMPANY</b>  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>(UNKNOWN)</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>(UNKNOWN)</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SANDRA BLOCH / DAUGHTER-IN-LAW</b>   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 SUNNYKING DRIVE - REISTERSTOWN, MD 21136</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHEVRA AHAVAS CHESED</b>   |   | 20c. Location - City or Town, State<br><b>9/25/00 RANDALLSTOWN, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>   |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic - Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's Disease</b><br><b>Dementia</b>   |  |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>027123</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>9/22/00</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Judith Minkov 750 Main St Reisterstown, MD 21136</b>   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  | 32. Registrar's Signature<br>   |   |  |  |

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Amended Item#27 per PHYG787 9/28/2000 EW  
 Amended Item#28b per PHYG787 9/27/2000 EW  
 State of Maryland / Department of Health and Mental Hygiene  
 Certificate of Death

Reg. No.

00 30428

|   |   |                          |   |   |   |   |  |  |  |  |  |  |  |
|---|---|--------------------------|---|---|---|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Nancy L. Chesser                                      |                          |   |   | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 19, 2000  |   |  |  | 3. Time of Death<br>5:30 a.m.                                    |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL CENTER |                          |   |   | 4b. City, Town, or Location of Death<br>ROSEDALE  |   |  |  | 4c. County of Death<br>BALTIMORE                                 |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>216-28-1784  |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>68 Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br>July 3 1932 |  | 9. Birthplace (State or Foreign Country)<br>Maryland             |  |  |  |  |
|   | Usual Residence of Decedent   |                          |   |   |   |   |  |  |  |  |  |  |  |
| 10a. State<br>Md.   |   | 10b. County<br>Baltimore |   | 10c. City, Town or Location<br>Parkville  |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |  |  |  |
| 10e. Street and Number<br>8810 Walther Blvd.  |   |                          |   | 10f. Zip Code<br>21234  |   |   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) +4   |   |                          |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |   |   |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Kroll  |   |                          |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Meade Young  |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mr. D. Bruce Chesser/Son  |   |                          |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>504 Hatherleigh Rd. Baltimore, Md. 21212 |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                          |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Mem. Pk.  |   |   |  | Date<br>9-22-00  |  | 20c. Location - City or Town, State<br>Elkridge, Md.   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |   |                          |   |   |   | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                     |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. RESPIRATORY FAILURE<br>Due to (or as a consequence of):<br><br>b. CEREBROVASCULAR ACCIDENT<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |                          |   |   |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>ONE MONTH<br>ONE MONTH   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ASTHMA, HIP FRACTURE, MYOCARDIAL INFARCTION<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>9/19/00<br>Approved by medical examiner   |   |                          |   |   |   |   |  |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                          |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                          |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                          |   | 28a. Date of Injury (Month, Day, Year)<br>AUGUST 12, 2000   |   | 28b. Time of Injury<br>Unknown M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No    |  | 28d. Describe how injury occurred<br>TRIPPED ON CARPET |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>HOME  |   |                          |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>8810 WALTHER BLVD.<br>#1221, BALTIMORE, MD 21234  |   |   |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |                          |   |   |   |   |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |                          |   |   |   | 29c. License number<br>RD 203364  |  |  | 29d. Date signed (Month, Day, Year)<br>9/19/00                   |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>GRACE MCGIBBON, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237   |   |                          |   |   |   |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |   |                          |   |   |   | 32. Registrar's Signature<br>   |  |  |  |  |  |  |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30429

|  |   |  |  |   |  |  |                                |  |  |  |
|--|---|--|--|---|--|--|--------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Clinton Lee Crawford  |  |  |   | 2. Date of Death<br>Month Day Year<br>September 22 2000  |  |                                |  | 3. Time of Death<br>10:00 AM                                     |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>708 Wyndhurst Avenue  |  |  |   | 4b. City, Town, or Location of Death<br>Baltimore  |  |                                |  | 4c. County of Death<br>N/A                                       |  |
| Funeral<br>Director  | 5. Social Security Number<br>213-03-7362  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>99 Yrs.  |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.                                   |  |
|  | 8. Date of Birth (Month, Day, Year)<br>October 21 1900  |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |   | 10a. State<br>Maryland   |  | 10b. County<br>N/A             |  | 10c. City, Town or Location<br>Baltimore                         |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |  |  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |                                |  |  |  |
|  | 10e. Street and Number<br>708 Wyndhurst Avenue  |  |  |   | 10f. Zip Code<br>21210   |  |                                |  | 10g. Citizen of What Country?<br>United States                   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW I |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Vice President  |  |                                |  | 16b. Kind of Business/Industry<br>Construction                   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Clinton Lee Crawford   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Miranda Margaret McMackin   |  |                                |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Edward S. Crawford (Son)  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>614 St. John Road Baltimore, Maryland 21210   |  |                                |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Cemetery   |   | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  | 20d. Date<br>9/25/00           |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Steve T. Zitter  |  |  |   | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home, Inc.<br>6500 York Road Baltimore, Maryland 21212  |  |                                |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cardio-pulmonary Arrest<br>Due to (or as a consequence of):<br>b. Arteriosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   | Approximate Interval Between Onset and Death   |  |                                |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                |  |  |  |
|  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                | 28d. Describe how injury occurred  |  |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  |   |  | 28t. Location (Street and Number or Rural Route Number, City or Town, State)         |                                |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |  | 29b. Signature and title of certifier<br>Raymond W. Wilson, M.D.  |  |  |                                | 29c. License number<br>D41476  |  |  |
|  |   |  |  | 29d. Date signed (Month, Day, Year)<br>September 22, 2000   |  |  |                                |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Raymond W. Wilson, M.D. 6565 N. Charles Street Towson, Maryland 21204  |   |  |  |   |  |  |                                |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000   |   |  |  | 32. Registrar's Signature<br>B. Sparks  |  |  |                                |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30430

amend item 20b per fh G787 9/27/00 yf

Certificate of Death

Reg. No.

|   |  |   |  |   |  |  |                                |  |  |   |  |                                   |  |
|---|--|---|--|---|--|--|--------------------------------|--|--|---|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Lillian Cerstvik                   |   |  |   | 2. Date of Death<br>Month Day Year<br>September 24, 2000 |  |                                |  | 3. Time of Death<br>8:50 AM              |   |  |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Copper Ridge |   |  |   | 4b. City, Town, or Location of Death<br>Sykesville       |  |                                |  | 4c. County of Death<br>Carroll           |   |  |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>143-48-7195                                       |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>97 Yrs.                |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.           |   |  |                                   |  |
|   | 8. Date of Birth (Month, Day, Year)<br>September 16, 1903                      |   | 9. Birthplace (State or Foreign Country)<br>New Jersey                     |   | 10a. State<br>MD   |  | 10b. County<br>Frederick       |  | 10c. City, Town or Location<br>Frederick |   |  |                                   |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>6862 Buckthorn Court  |  | 10f. Zip Code<br>21703   |                                | 10g. Citizen of What Country?<br>USA   |  |   |  |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10           |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                  |  |                                   |  |
| 16b. Kind of Business/Industry<br>Own Home  |  | 17. Father's Name (First, Middle, Last)<br>Adam Janco   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Zuzanna Hrniciar   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Vera Matthews Daughter   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>39 Thomas Lane Setauket, NY 11733 |  |   |  |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hollywood Memorial Park   |  | Date<br>09/29   |  | 20c. Location - City or Town, State<br>Union, NJ   |                                | 21. Signature of Funeral Service Licensee<br>Robert Woodard  |  | 22. Name and Address of Facility<br>Sterling Ashton Schwab Funeral Home, Inc.<br>736 Edmondson Ave. Baltimore, MD 21228                 |  |                                   |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Congestive Heart Failure<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>Two days  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                              |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |                                | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>MD  |                                | 29c. License number<br>D33184  |  | 29d. Date signed (Month, Day, Year)<br>September 24, 2000   |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Jonathan Kushner 114 Business Center Drive Reisterstown, MD   |  | 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |  | 32. Registrar's Signature<br>Benjamin Sparks  |  |  |                                |  |  |   |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene 00 30431

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>Raymond Cannoles</u>  |   | 2. Date of Death<br>Month <u>SEPTEMBER</u> Day <u>22</u> Year <u>2000</u>   |   | 3. Time of Death<br><u>10:46 AM</u>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</u>  |   | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>  |   | 4c. County of Death<br><u>N/A</u>  |
| Funeral<br>Director   | 5. Social Security Number<br><u>214-12-8800</u>  | 6. Sex<br><u>♂</u> M <input type="checkbox"/> F <input type="checkbox"/>  | 7. Age (In yrs. last birthday)<br><u>78</u> Yrs.  | If Under 1 Year<br>Months <u>  </u> Days <u>  </u>  | If Under 24 Hrs.<br>Hours <u>  </u> Min. <u>  </u>   |
|   | 8. Date of Birth (Month, Day, Year)<br><u>Oct. 31, 1921</u>  |   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   | 10a. State<br><u>Maryland</u>   |   | 10b. County<br><u>Baltimore</u>  |
|   | 10c. City, Town or Location<br><u>Dundalk</u>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|   | 10e. Street and Number<br><u>2031 Inverton Road</u>  |   | 10f. Zip Code<br><u>21222</u>   |   | 10g. Citizen of What Country?<br><u>United States</u>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>WWII</u>             |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <u>  </u> |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |   | 15. Decedent's Education (Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u><br><u>4 Years</u>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Painter</u>  |
|   | 16b. Kind of Business/Industry<br><u>Steel Industry</u>  |   | 17. Father's Name (First, Middle, Last)<br><u>William David Cannoles</u>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Blanche Fredericka Wiggington</u>  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Mrs. Emma L. Cannoles (Wife)</u>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2031 Inverton Road Dundalk, Maryland 21222</u>                        |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>  </u>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Holly Hill Mem. Gdns. 9/26/2000</u>  |   | 20c. Location - City or Town, State<br><u>Middle River, MD</u>   |
|   | 21. Signature of Funeral Service Licensee<br><u>Stephanie Massey</u>   |   | 22. Name and Address of Facility<br><u>Duda-Ruck Funeral Home of Dundalk, Inc.</u><br><u>7922 Wise Ave. Dundalk, Maryland 21222</u>                                       |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Renal insufficiency, bladder cancer</u> |   | 23c. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown       |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>  </u> |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><u>  </u>  |   | 28b. Time of Injury<br><u>  </u> M <u>  </u>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><u>  </u>  |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><u>  </u> |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><u>Michael Beland Medical Doctor</u>   |   | 29c. License number<br><u>RES-000</u>   |  |
| 29d. Date signed (Month, Day, Year)<br><u>9/21/2000</u>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>600 North Wolfe Street Baltimore Maryland 21287</u>  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><u>SEP 27 2000</u>   |  | 32. Registrar's Signature<br><u>Benjamin B. Sparks</u>  |   |   |  |



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State of Maryland / Department of Health and Mental Hygiene

00 30432

## Certificate of Death

Reg. No.

|  |   |   |   |                                |  |
|--|---|---|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>FAY</b>  |   | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>24</b> Year <b>2000</b>   |                                | 3. Time of Death<br><b>11:45 AM</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>JEWISH CONVALESCENT &amp; NURSING HOME</b>   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                | 4c. County of Death<br><b>BALTIMORE</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>126-14-2184</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>93</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 17, 1907</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>NY</b>   |                                |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent   |   |   |                                |  |
|  | 10a. State<br><b>MD</b>   | 10b. County<br><b>BALTIMORE</b>   | 10c. City, Town or Location<br><b>OWINGS MILLS</b>  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>10812 SHERWOOD HILL ROAD</b>   |   | 10f. Zip Code<br><b>21117</b>   |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:         |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)                               |                                |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>   |   | 16b. Kind of Business/Industry<br><b>OWN HOME</b>   |                                |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>SAMUEL</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARA SCHULMAN</b>   |                                |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>PAUL CHERCHES / SON</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10812 SHERWOOD HILL ROAD - OWINGS MILLS, MD 21117</b> |                                |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>NEW MONTEFIORE CEMETERY</b>  |                                | 20c. Location - City or Town, State<br><b>9/25/00 PINELAWN, NY</b>   |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>                               |                                |  |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Cerebral Thrombosis</b><br>Due to (or as a consequence of):<br>b. <b>Atherosclerotic Cardiovascular Disease &gt;5 years</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |                                |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |                                |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |                                |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |                                |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |                                |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |                                |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>SEP 27 2000</b>  |                                |  |
|  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                |  |
|  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |   |   |                                |  |
| State<br>Registrar   | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |                                |  |
|  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D15872</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>September 24 2000</b>  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Harold B. Bob MD 25 MAIN STREET Reisterstown, Md 21136</b>   |   |   |                                |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>                      |   | 32. Registrar's Signature<br> |   |                                |  |



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State of Maryland / Department of Health and Mental Hygiene

00 30433

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>David Coleman Jr.   |  |   |  | 2. Date of Death<br>Month Day Year<br>September 24, 2000   |  | 3. Time of Death<br>9:15 PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>513 Rossiter Ave.   |  |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |  | 4c. County of Death<br>N/A  |  |
| Funeral<br>Director   | 5. Social Security Number<br>229-05-1315  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>89 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Aug. 16, 1911   | 9. Birthplace (State or Foreign Country)<br>Virginia                        |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland  | 10b. County<br>N/A   | 10c. City, Town or Location<br>Baltimore  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
|   | 10e. Street and Number<br>1616 E. Coldspring Lane   |  |   | 10f. Zip Code<br>21218   |  | 10g. Citizen of What Country?<br>USA   |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: African American |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2 College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Tailor                                   |  | 16b. Kind of Business/Industry<br>Self employed  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br>David M. Coleman   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Fannie Morton   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print) (daughter)<br>Mrs. Fannie Cunningham   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>513 Rossiter Ave. Balto. Md. 21212  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arbutus Mem. Park   |  | 20c. Location - City or Town, State<br>10/3/2000 Balto. Md.  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>Joseph L. Russ   |  | 22. Name and Address of Facility<br>Joseph L. Russ Funeral Home<br>2222 W. North Ave. Balto. Md. 21216  |  |  |  |   |  |
|   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CARDIAC ARREST<br>Due to (or as a consequence of):<br>b. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>c. MYOCARDIAL INFARCTION<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death<br>IMMEDIATE<br>SIX YEARS<br>TEN YEARS |  |   |  |  |  |   |  |
|   | 23b. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>f. CHRONIC WEIGHT LOSS   |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>CHRONIC WEIGHT LOSS  |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) DAUGHTER |   |  |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |
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| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |   |  |
| 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |   | 28c. Injury  |  |  |   |  |





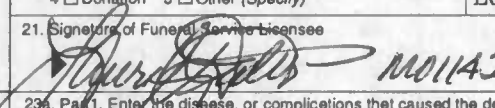
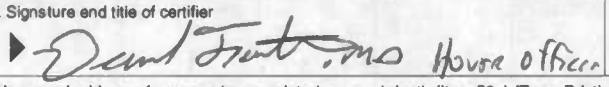

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State of Maryland / Department of Health and Mental Hygiene

00 30434

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |  |   |  |
|--|---|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Katharine Z. Dempsey</b>   |   |   |  | 2. Date of Death<br>Month Day Year<br><b>September 25 2000</b>   |  |  |  | 3. Time of Death<br><b>05:57 PM</b>                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  |  |  | 4c. County of Death<br><b>---</b>                           |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-34-2685</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>07-12-1912</b>               |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|  | Usual Residence of Decedent   |   |   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Catonsville</b>           |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><b>126 South Hilltop Road</b>   |   |   |  | 10f. Zip Code<br><b>21228</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                            |  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify <b>White</b> |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |   | College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>                      |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Christian Zies</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Dorteia Richwein</b>   |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Karen Hilton</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>126 South Hilltop Road, Catonsville, Maryland 21228</b>                                  |  |  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>09-29-2000 Baltimore, Maryland</b>   |  |  |  |   |  |
|  | 21. Signature of Funeral Home Licensee<br>  |   | 22. Name and Address of Facility<br><b>Witzke Funeral Home, Inc.<br/>1630 Edmondson Avenue, Catonsville, Maryland 21228</b>                       |  |  |  |  |  |   |  |
|  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Subarachnoid Hemorrhage</b> |   |   |  | Approximate Interval Between Onset and Death<br><b>2 Days</b>  |  |  |  |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>b. Subdural Hematoma</b>   |   |   |  | <b>2 Days</b>  |  |  |  |   |  |
|  | <b>c. Idiopathic Thrombocytopenic Purpura</b>   |   |   |  | <b>years</b>   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Osteoarthritis</b>  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of injury (Month, Day Year)   |   | 28b. Time of injury<br><b>M</b>  |  |  |  |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   | 28e. Place of injury - At home, term, street, factory, office building, etc. (Specify)   |  |  |  |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |  |  |  |   |  |
| 29b. Signature and title of certifier<br><br><b>Daniel Feinstein, MD House Officer</b>  |   | 29c. License number<br><b>P12590</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>September 25, 2000</b>   |  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Daniel Feinstein, MD 900 Caton Ave Baltimore, Maryland 21229</b>  |   |   |   |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |   | 32. Registrar's Signature<br>   |   |  |  |  |  |  |   |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30435

|   |   |   |   |  |   |   |                                      |  |   |  |
|---|---|---|---|--|---|---|--------------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Delarence Daniels</b>                                |   |   |  | 2. Date of Death<br>Month <b>September</b> Day <b>25</b> Year <b>2000</b> |   |                                      |  | 3. Time of Death<br><b>4:00 am</b>            |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>                    |   |                                      |  | 4c. County of Death<br><b>Prince Georges</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>238-46-9892</b>   |   | 6. Sex<br><b>16</b> M <input type="checkbox"/> F      |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.                          |   | If Under 1 Year<br>Months Days       |  | If Under 24 Hrs.<br>Hours Min.                |  |
|   | 8. Date of Birth (Month, Day, Year)<br><b>April 2, 1933</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>NC</b> |  | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Prince Georges</b> |  | 10c. City, Town or Location<br><b>Clinton</b> |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>8500 Mike Shapiro Drive</b>   |   | 10f. Zip Code<br><b>20735</b>   |                                      | 10g. Citizen of What Country?<br><b>United States</b>                    |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <b>Unk.</b><br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |                                      |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>0</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |   | 16b. Kind of Business/Industry<br><b>Construction</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Paul Franklin Daniels</b>   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pearl Manley</b> |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Vedell Walker / Sister</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3206 Marcando Lane, Upper Marlboro Maryland 20774</b>   |   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Wayman Church Cemetery</b>   |                                      | 20c. Date<br><b>September 28, 2000</b>                                   |   |  |
| 20d. Location - City or Town, State<br><b>Enfield, NC</b>   |   | 21. Signature of Funeral Service Licensee<br><b>Victor P. Doda, Jr.</b>   |   | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 East Fort Avenue, Baltimore Maryland 21230</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial infarct</b><br>Due to (or as a consequence of):<br><b>b. End stage renal failure</b><br>Due to (or as a consequence of):<br><b>c. Diabetes mellitus &amp; Diabetes foot and PVD</b><br>Due to (or as a consequence of):<br><b>d. Congestive Arhythmia &amp; Wernicke's Brain</b> |                                      | Approximate Interval Between Onset and Death                             |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Blind</b>  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                                      |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)   |                                      | 28b. Time of Injury<br><b>M</b>  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                      |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>K. Daniels</b>  |   | 29c. License number<br><b>D25640</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>September 25, 2000</b>  |                                      |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KHASROW Davachi 1328 Southern Ave Wash, DC 20032</b>   |   | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br><b>B Sparks</b>   |   |   |                                      |  |   |  |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

00 30436

Reg. No.

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Michael Paul Garrett Deese   |   | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 23, 2000  |  | 3. Time of Death<br>01:16 AM   |
|  | 4e. Facility Name (If not institution, give street and number)<br>MARTIN BOULEVARD AND TRANSVERSE AVENUE   |   | 4b. City, Town, or Location of Death<br>Middle River  |  | 4c. County of Death<br>BALTIMORE   |
| Funeral<br>Director  | 5. Social Security Number<br>220-92-9967   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br>21 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>Sept. 9, 1979 | 9. Birthplace (State or Foreign Country)<br>Maryland   |
|  | Usual Residence of Decedent  |   |   |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   | 10b. County<br>Baltimore  | 10c. City, Town or Location<br>Essex  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br>25 Breaker Court   |   | 10f. Zip Code<br>21221  |  | 10g. Citizen of What Country?<br>United States   |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 Years<br>College (1-4 or 5+)                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Contracting   |
|  | 16b. Kind of Business/Industry<br>Home Improvement   |   | 17. Father's Name (First, Middle, Last)<br>Edmund Phillip Garrett   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Kathy Irene Brown   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Kathy I. Deese (Mother)  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2957 Cornwall Road Dundalk, Maryland 21222           |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  | 20c. Location - City or Town, State<br>Brooklyn, Maryland  |
|  | 20d. Date<br>9/27/2000   |   | 20e. Location - City or Town, State<br>Brooklyn, Maryland   |  |  |
|  | 21. Signature of Funeral Service Licensee  |   | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave Dundalk, Maryland 21222                                  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                           |  |  |
| 23c. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Multiple Injuries<br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):   |  | 23d. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE |   |  |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>9-23-00   |   | 28b. Time of Injury<br>0100 M                        |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br>pedestrian struck by auto  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Roadway  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Martin Blvd.  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>David R Fowler   |   | 29c. License number<br>OCME                          |  |
| 29d. Date signed (Month, Day, Year)<br>SEPTEMBER 23, 2000  |  | 29e. Date signed (Month, Day, Year)<br>SEPTEMBER 23, 2000   |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David R Fowler   |  | 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |   |  |  |
| 32. Registrar's Signature<br>B. Sparks   |  | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>111 Penn Street, Baltimore, Maryland 21201  |   |  |  |





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State of Maryland / Department of Health and Mental Hygiene 00 30437

## Certificate of Death

Reg. No.

|  |   |  |   |                                |  |   |  |
|--|---|--|---|--------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Maria Dixon   |  |   |                                | 2. Date of Death<br>Month Day Year<br>September 24, 2000   |   | 3. Time of Death<br>8:20 AM                                      |
|  | 4a. Facility Name (If not institution, give street and number)<br>Franklin Square Hospital Center   |  |   |                                | 4b. City, Town, or Location of Death<br>Rosedale   |   | 4c. County of Death<br>Baltimore                                 |
| Funeral<br>Director                              | 5. Social Security Number<br>437-66-9248  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>65 Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Jan. 7, 1935   | 9. Birthplace (State or Foreign Country)<br>Germany              |
|  | Usual Residence of Decedent   |  |   |                                |  |   |  |
| To Be Completed by Funeral Director              | 10e. State<br>Maryland  | 10b. County<br>Baltimore   | 10c. City, Town or Location<br>Dundalk  |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 10e. Street and Number<br>2606 Liberty Parkway  |  |   | 10f. Zip Code<br>21222         |  | 10g. Citizen of What Country?<br>United States  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>4 Years   |  | College (1-4 or 5+)   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker   |   | 16b. Kind of Business/Industry<br>Own Home                       |
|  | 17. Father's Name (First, Middle, Last)<br>Leonard Steinberger  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Viktoria Friedl   |   |  |
| To Be Completed by Physician/Medical Examiner    | 19e. Informant's Name/Relationship (Type, Print) (Daughter)<br>Mrs. Patricia L. LaMartina   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7855 St. Fabian Lane Dundalk, Maryland 21222  |   |  |
|  | 20e. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.   |                                | Date<br>9/29/2000  | 20c. Location - City or Town, State<br>Towson, Maryland   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222   |                                |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Coronary Artery Disease<br>Due to (or as a consequence of):<br>c. Hypertension<br>Due to (or as a consequence of):<br>d. Cardiac Arrhythmias |  |   |                                |  |   |  |
|  | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                                |  |   |  |
| To Be Completed by Physician/Medical Examiner    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |                                |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                   |  |
|  |   |  |   |                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |                                | 28b. Time of Injury<br>M   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| State Registrar                                  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |                                | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>53547                                     |
|  |   |  |   |                                | 29d. Date signed (Month, Day, Year)<br>9/24/00   |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>S. Jagannath MD. 9000 Franklin Square Drive Baltimore Maryland 21237  |  |   |                                |  |   |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000 |   | 32. Registrar's Signature<br>  |   |                                |  |   |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30438

## Certificate of Death

Reg. No.

|   |   |   |   |  |   |   |  |  |
|---|---|---|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>TILLYE DAVID</b>   |   |   |  | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>21</b> , Year <b>2000</b>   |   | 3. Time of Death<br><b>5:50 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7 SLADE AVENUE #815</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-30-2336</b>   |   | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.  |   | 6. Date of Birth (Month, Day, Year)<br><b>MAY 1, 1908</b>  |  |
|   | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director   | 10e. Street and Number<br><b>7 SLADE AVENUE #815</b>  |   |   |  | 10f. Zip Code<br><b>21208</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROPRIETOR</b>  |   | 16b. Kind of Business/Industry<br><b>WOMENS CLOTHES</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ISAAC WISE</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>(UNKNOWN) (UNKNOWN)</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>JOSEPH DAVID / SON</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2 RESERVOIR CIRCLE #100 - BALTIMORE, MD 21208</b>   |   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHIZUK AMUNO (ARLINGTON)</b>   |  | Date<br><b>9/24/00</b>  |   | 20c. Location - City or Town, State<br><b>BALTIMORE, MD</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - BALTIMORE, MD 21208</b>  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. HYPERTENSIVE HEART DISEASE</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |   |   |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|   |   |   |   |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
|   |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |   |   |  |  |
| 29b. Signature and title of certifier<br>  |   |   |   | 29c. License number<br><b>D19317</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>9/22/00</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BORIS KERZNER 1838 GREENWICH RD BALTIMORE MD 21208</b>   |   |   |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br>   |   |  |   |   |  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30439

Amended Item#23apt1 perPHYG787 9/27/2000 EW

## Certificate of Death

Reg. No.

|   |  |   |                               |  |  |   |  |  |
|---|--|---|-------------------------------|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Gene ELLER</b>  |   |                               |  | 2. Date of Death<br>Month <b>August</b> Day <b>13</b> Year <b>00</b> |   | 3. Time of Death<br><b>0735</b>                            |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical System</b> |   |                               |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |   | 4c. County of Death<br><b>Baltimore</b>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-42-2569</b>  |   | 6. Sex<br><b>XXM 2 F</b>      |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>June 3, 1944</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b> |  | 10b. County<br><b>Harford</b>  |   | 10c. City, Town or Location<br><b>Aberdeen</b>             |  |
| 10d. Inside City Limits<br><b>XX Yes 2 No</b>   |  | 10e. Street and Number<br><b>58 Swan Street</b>   |                               | 10f. Zip Code<br><b>21001</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>  |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No</b>  |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b>                                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>                                      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Driver</b>  |                               | 16b. Kind of Business/Industry<br><b>Cement Truck</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Bryant A. Eller</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosa Fae Neaves</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rosa Fae Eller (mother)</b>  |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>58 Swan Street, Aberdeen, MD 21001</b>   |  | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b> |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BelAir Memorial Gardens</b>                                      |  | 20c. Date<br><b>8/17/00</b>   |                               | 20d. Location - City or Town, State<br><b>BelAir, Maryland</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Kursken Amy Hingst</b>                                      |  |  |
| 22. Name and Address of Facility<br><b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Sepsis</b><br><b>b. MYOCARDIAL INFARCTION</b><br><b>c. FULL CARDIAC ARREST</b><br><b>d. ANOXIC BRAIN INJURY</b>                        |                               | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>6 WEEKS</b><br><b>6 WEEKS</b><br><b>6 WEEKS</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>            |  |  |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>  |                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Myocardial Infarction</b><br><b>Full Cardiac Arrest</b><br><b>Anoxic Brain Injury</b> |  | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |  |
| 26. Place of Death (Check only one)<br><b>Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)</b> |  | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |                               | 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury<br/>M 28c. Injury at Work? 1 Yes 2 No</b>   |  | 28d. Describe how injury occurred   |  |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b> |                               | 29b. Signature and title of certifier<br><b>And Reis-Holt MD</b>   |  | 29c. License number<br><b>ID # 13088</b>  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>8/13/00</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Amber Reiss-Holt - University of Maryland Medical System</b>   |                               | 31. Date filed (Month, Day, Year)<br><b>AUG 18 2000</b>  |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible handwritten text covering the page]*



*[Faint handwritten text at the bottom center]*

*[Faint handwritten text at the bottom right]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30440

amend item 23a,27, 28a,b,c,d,e,f per me G790 12/12/00 **Certificate of Death**

Reg. No.

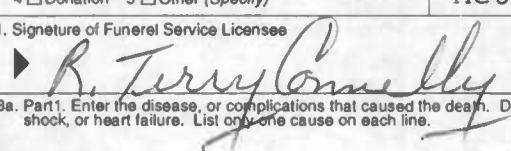
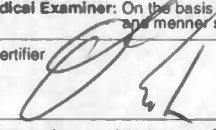
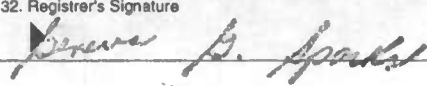
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner  
Funeral Director

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>DONNA M ENGLE</b>  |  | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>22</b> Year <b>2000</b>   |  | 3. Time of Death<br><b>14:57 PM</b>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>SAINT JOSEPH'S MEDICAL CENTER</b>  |  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| 5. Social Security Number<br><b>478-64-9093</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.  |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Feb.16,1949</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Iowa</b>   |  |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Middle River</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>22 Blister Street</b>  |  | 10f. Zip Code<br><b>21220</b>   |  |
| 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)   |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Subscription Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Girl's Life</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Robert L. McDonough</b>   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence M Hadley</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph R. Engle Jr./husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22 Blister Street Baltimore Maryland 21220</b>  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro CREmatoryInc.</b>  |  | 20c. Location - City or Town, State<br><b>9/27/00 Baltimore Md.</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex</b><br><b>300 MACE AVE. Baltimore MD 21221</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. CARDIAC TAMPONADE DUE TO RUPTURED CORONARY ARTERY</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |  |
| 28a. Date of Injury (Month, Day Year)<br><b>9/22/00</b>   |  | 28b. Time of Injury<br><b>unknown M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28d. Describe how injury occurred<br><b>unknown</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>St. Joseph Medical Center</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>7601 Osler Drive Towson, Maryland 21204</b>  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  |
| 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 23, 2000</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R Fowler</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  |
| 32. Registrar's Signature<br>   |  |   |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND#23A&amp;B PER MD. G788 10-5-2000 JAB

Certificate of Death

Reg. No.

00 30441

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor Margaret Feldmann

2. Date of Death

September 18, 2000

3. Time of Death

7:20 A.M.

4a. Facility Name (If not institution, give street and number)

Good Samaritan Nursing Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-07-4547

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

September 11, 1909

9. Birthplace (State or Foreign Country)

Baltimore, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1601 East Belvedere Ave.

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Stenographer

16b. Kind of Business/Industry

Small Business Admin.

17. Father's Name (First, Middle, Last)

Joseph

Feldmann, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth

Fleischmann

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jane F. Cook / Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8228 Burnley Road Ruxton, Maryland 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Most Holy Redeemer Cemetery 9/22/2000

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Earl L. Canapp, CFSP

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204-2515

Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

SEPSIS

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Urinary Tract Infection

Due to (or as a consequence of):

URINARY TRACT INFECTION

2 weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dehydrationAlzheimer's dementiadecubitus ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28t. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Earl L. Canapp

29c. License number

D 28987

29d. Date signed (Month, Day, Year)

9-18-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL SPERLING, M.D. 5601 LOCK RAVEN BLVD BALTO. MD 21239

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

Benita B Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30442

AMEND ITEM: #6 PER F.H. G787 9-28-00 WR.

Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |   |  |  |  |  |
|---|---|---|---|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Walter Lee Feddon   |   |   |   |  | 2. Date of Death<br>Month Day Year<br>September 22, 2000   |   |  | 3. Time of Death<br>1:22 pm                          |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Greater Baltimore Medical Center  |   |   |   |  | 4b. City, Town, or Location of Death<br>Towson   |   |  | 4c. County of Death<br>Baltimore                     |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>219 05 5819  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>79 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 2, 1921  |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |  |
|   | Usual Residence of Decedent   |   |   |   |  | 10a. State<br>Maryland   |   | 10b. County<br>Baltimore   |  | 10c. City, Town or Location<br>Parkville |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  | 10e. Street and Number<br>4010 Marjeff Place "Apt D"   |   | 10f. Zip Code<br>21236   |  | 10g. Citizen of What Country?<br>USA     |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3 College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                                  |   |  |  | 16b. Kind of Business/Industry<br>Construction        |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>John Feddon  |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Zeola Smith   |   |  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Mary Jane Feddon (Wife)   |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4010 Marjeff Place "Apt D" Baltimore, Md. 21236 |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Crematory   |   | 20c. Date<br>9/25/2000   |  | 20d. Location - City or Town, State<br>Baltimore, Md. |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>John W. Burkowski  |   | 21. License Number<br>MO1091  |   | 22. Name and Address of Facility<br>Bruzdinski Funeral Home P.A.<br>1407 Old Eastern Avenue Essex, Md. 21221   |  |   |  |  |  |  |
|   | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |  |   |  |  |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)   |   | a. VENTRICULAR FIBRILLATION<br>Due to (or as a consequence of):   |   |  |  |   |  |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |   | b. CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):<br>c. CARDIOMYOPATHY<br>Due to (or as a consequence of):                               |   |  |  |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  |  |   |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   |   |   |   |  |  |   |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |   |   |  |  |   |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |   |   |  |  |   |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA |   | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 28d. Describe how injury occurred                                |  |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>[Signature]  |   |   |   |   | 29c. License number<br>D21398  |  | 29d. Date signed (Month, Day, Year)<br>9-22-00        |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>G. ROBERT MEDAULT, 6565 N. CHARLES ST, BA, MD. 21204  |   |   |   |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |   |   |   |   | 32. Registrar's Signature<br>[Signature]   |  |   |  |  |  |  |

Feddon, Walter

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Death-5000-30001-30200

00-30445

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30443

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |  |
|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Viola H. FREDERICKS</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>Sept. 26 2000</b>   |  | 3. Time of Death<br><b>11:35 a.m.</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Lorien Nursing Home</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Columbia</b>  |  | 4c. County of Death<br><b>Howard</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>104-22-2416</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jul 6, 1910</b>                                   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Howard</b>   |  | 10c. City, Town or Location<br><b>Columbia</b>  |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>6334 Cedar Lane</b>  |  | 10f. Zip Code<br><b>21044</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2+</b> College (1-4 or 5+) <b>2+</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Home</b>  |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles Wickes</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Stevenson</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Carole J. Dixon</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2617 Orchard Ave. Ellicott City, Maryland 21043</b>                                      |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakeview Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Tupperlake, New York</b>   |  | 20d. Date<br><b>09/30/00</b>  |  |
|  | 21. Signature of Funeral Service Director<br>   |  | 22. Name and Address of Facility<br><b>Slack Funeral Home, P.A.<br/>3871 Old Columbia Pike Ellicott City, MD 21043</b>  |  |  |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>7 YEARS</b> |  |   |  |  |  |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>  |  |   |  |  |  |   |  |
|  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |  |
|  | 29b. Signature and title of certifier<br><br><b>MD</b>   |  |   |  | 29c. License number<br><b>D51860</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPT 26, 2000</b>                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JONATHAN FISH MD 3460 ELLICOTT CT A2 #103 ELLICOTT CT, MD 21043</b>   |   |  |   |  |  |  |   |  |
| State Registrar  | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  | 32. Registrar's Signature<br>  |  |  |  |   |  |

ORIGINAL





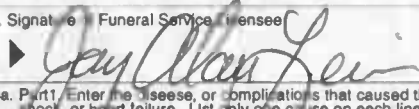
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30444

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>AGNES L. FRENKIL</b>                             |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 20, 2000</b>  |  | 3. Time of Death<br><b>4:30PM</b>                        |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>820E SPRING BOTTOM WAY</b> |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>                  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-26-4677</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                           |
|   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 3, 1912</b>                                      |   | 9. Birthplace (State or Foreign Country)<br><b>ENGLAND</b>   |  |  |
| Usual Residence of Decedent   |   |   |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |
| 10e. Street and Number<br><b>8208 SPRING BOTTOM WAY</b>   |   |   | 10f. Zip Code<br><b>21208</b>  |  | 10g. Citizen of What Country?<br><b>ENGLAND</b>          |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROPRIETOR</b>                       |  | 16b. Kind of Business/Industry<br><b>UNIFORM COMPANY</b> |
| 17. Father's Name (First, Middle, Last)<br><b>ALFRED BARKHAM</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LILLIAN MORRIS</b>   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JANE FRENKIL / DAUGHTER</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8208 SPRING BOTTOM WAY - BALTIMORE, MD 21208</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HAR SINAI CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>9/25/00 OWINGS MILLS, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN, ROAD - BALTIMORE, MD 21208</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   |   | e. <b>metastatic Breast cancer</b> 8 months   |  |  |  |
| Due to (or as a consequence of):  |   |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |   | b. Due to (or as a consequence of):   |  |  |  |
|   |   | c. Due to (or as a consequence of):   |  |  |  |
|   |   | d. Due to (or as a consequence of):   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>DY4944</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>September 21, 2000</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>3333 North Calvert Street Baltimore Maryland 21218</b>   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br>   |  |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30445

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUDITH FINE

2. Date of Death  
Month Day Year

SEPTEMBER, 25, 2000 4:45AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN BALTIMORE

4c. County of Death

5. Social Security Number

092-10-3787

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

NOV. 3, 1913

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9209 OWINGS CHOICE COURT

10f. Zip Code

21117

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SECRETARY

16b. Kind of Business/Industry

CLERICAL

17. Father's Name (First, Middle, Last)

ISRAEL

KLAR

18. Mother's Name (First, Middle, Maiden Surname)

HELEN

HOROWITZ-HORN

19a. Informant's Name/Relationship (Type, Print)

ARLENE LEVY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9209 OWINGS CHOICE COURT - OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

SHAAREI ZION CEMETERY

Date

9/26/00

20c. Location - City or Town, State

ROSEDALE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

PNEUMONIA

Due to (or as a consequence of):

b.

SEPSIS

Due to (or as a consequence of):

c.

RENAL FAILURE

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORTHWEST HOSPITAL CENTER, RANDALLSTOWN, MD

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

Beverly B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 30446

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH EARL GITTINGS, JR.

2. Date of Death

09 25 2000

3. Time of Death

6:55AM

4a. Facility Name (If not institution, give street and number)

4513 MANNASOTA AVE.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

219-03-5631

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

March 1, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4513 Mannasota Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Owner - Vending

16b. Kind of Business/Industry

Vending Company

17. Father's Name (First, Middle, Last)

Joseph E. Gittings, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Morgan

19a. Informant's Name/Relationship (Type, Print)

Joseph Gittings, III (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

802 Tiffany Trail, Abingdon, Maryland 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Moreland Memorial Park

Date

9/28/00 Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home Inc.

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Congestive heart failure

Due to (or as a consequence of):

Coronary artery disease

Due to (or as a consequence of):

Ischemic cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

Subdural hematoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] Cheng

29c. License number

Bayview UPIN RES000

29d. Date signed (Month, Day, Year)

September 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter H. Cheng MD

Bayview Geriatric Center, Baltimore, Maryland

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

[Signature] Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#2 per PHYG787 9/27/2000 EW

## Certificate of Death

Reg. No.

00 30447

|  |   |  |   |   |  |  |  |  |                                   |  |
|--|---|--|---|---|--|--|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>EDGAR LESTER GREEN, JR.</b>  |  |   | 2. Date of Death<br>Month <b>September</b> Day <b>21</b> Year <b>2000</b>   |  |  | 3. Time of Death<br><b>3:30 P.M.</b>   |  |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Hospice of Baltimore at Gilchrist Center</b> |  |   | 4b. City, Town, or Location of Death<br><b>Towson</b>   |  |  | 4c. County of Death<br><b>Baltimore County</b>                                   |  |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-14-1646</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Sept 6, 1915</b>       |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |                                   |  |
|  | Usual Residence of Decedent   |  |   |   |  |  |  |  |                                   |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore County</b>                                     |   | 10c. City, Town or Location<br><b>Timonium</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                   |  |
| 10e. Street and Number<br><b>224 Charmuth Road</b>   |   |  |   | 10f. Zip Code<br><b>21093</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                      |  |  |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4or 5+) <b>5+</b>  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>President/ CEO</b>                |   |  | 16b. Kind of Business/Industry<br><b>Advertising Agency</b>      |  |  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edgar Lester Green, Sr.</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elva Taylor</b>   |  |  |  |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Judith Fennell Green (Wife)</b>   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>224 Charmuth Road, Timonium, Maryland 21093</b> |  |  |  |  |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>   |  | 20c. Date<br><b>9/26/2000</b>                                    |  | 20d. Location - City or Town, State<br><b>Pikesville, Maryland</b>                             |                                   |  |
| 21. Signature of Funeral Service Licensee<br><b>Martin D. Lawson</b>   |   |  |   | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Funeral Home, Inc.<br/>6500 York Road, Baltimore, Maryland 21212</b>                      |  |  |  |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. congestive heart failure</b><br>Due to (or as a consequence of):<br><b>b. ischemic heart disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>renal failure</b> |   |  |   |   |  |  |  |  |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |  |   |   |  |  |  |  |                                   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |   |  |  |  |  |                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |   |  |  |  |  |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |   |  |  |  |  |                                   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>   |   |  |   |   |  |  |  |  |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |   |   |  |  |  |  |                                   |  |
| 29b. Signature and Title of certifier<br><b>W. A. Riley, MD</b>  |   |  |   | 29c. License number<br><b>D25205</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>September 22, 2000</b> |  |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>W. A. Riley, GPMC 6701 N. Charles St. Balto. md 2120x</b>   |   |  |   |   |  |  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |   |  |   | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |  |  |  |                                   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30448

AMEND#26 PER MD. G787 9-027-2000 JAB

## Certificate of Death

Reg. No.

|  |  |   |  |   |   |
|--|--|---|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Juanita Golczynski</b>                  |   | 2. Date of Death<br>Month <b>September</b> Day <b>25</b> Year <b>2000</b>  |   | 3. Time of Death<br><b>2:55 P.M.</b>                  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>11 Shore Road</b> |   | 4b. City, Town, or Location of Death<br><b>Edgemere</b>  |   | 4c. County of Death<br><b>Baltimore</b>               |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-22-5974</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>74</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                        |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 25, 1926</b>                            |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |   |
| Usual Residence of Decedent  |  |   |  |   |   |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>   |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |   |
| 10e. Street and Number<br><b>2720 Kirkleigh Road</b>   |  |   | 10f. Zip Code<br><b>21222</b>  |   | 10g. Citizen of What Country?<br><b>United States</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                      |   | 16b. Kind of Business/Industry<br><b>Own Home</b>     |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Henry Rush</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Agnes Jones</b>  |   |   |
| 19a. Informant's Name/Relationship (Type, Print) (Son)<br><b>Mr. Joseph C. Golczynski</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3123 Cornwall Road Dundalk, Maryland 21222</b> |   |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | 20c. Location - City or Town, State<br><b>9/27/2000 Towson, Maryland</b>  |   |
| 21. Signature of Funeral Home<br>  |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>   |  |   |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>End stage emphysema</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):                       |  |   |  |   |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Rheumatoid arthritis</b>  |  |   |  |   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>RESIDENCE</b> |  |   |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |   |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |
| 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>018598</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/26/00</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sheldon Miller 404 Eastern Blvd Baltg Md 21221</b>  |  |   |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |  | 32. Registrar's Signature<br>   |  |   |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30449

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|---|---|---|---|--|--|--|---|--|---|---------------------------------|--|----------------------------------|--|--|---|---|---------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Elizabeth Horney</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>September 25, 2000</b>  |  | 3. Time of Death<br><b>6:03 AM</b>                                      |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2014 Middleborough Rd.</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Essex</b>   |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |   |                                 |  |                                  |  |  |   |   |                                 |
| Funeral<br>Director   | 5. Social Security Number<br><b>213 34 2051</b>   |   | 8. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.   |  | 6. Date of Birth (Month, Day, Year)<br><b>August 6, 1937</b>            |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Essex</b>                             |  |   |                                 |  |                                  |  |  |   |   |                                 |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 10e. Street and Number<br><b>2014 Middleborough Rd.</b>   |   |   |  | 10f. Zip Code<br><b>21221</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                         |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 17. Father's Name (First, Middle, Last)<br><b>Robert Harris</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sadaie Pittman</b>   |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Harry E. Horney (Husband)</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2014 Middleborough Rd. Baltimore, Md. 21221</b>  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens Of Faith Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>   |  | 20d. Date<br><b>9/28/2000</b>   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 21. Signature of Funeral Service Licensee<br><b>John W. Burkowski</b>   |   | 22. Name and Address of Facility<br><b>Bruzdinski Funeral Home P.A.<br/>1407 Old Eastern Avenue Essex, Md. 21221</b>                                  |  | 22. License Number<br><b>MO1091</b>  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | <table border="1"> <tr> <td rowspan="4">           Immediata Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>MYOCARDIAL INFARCTION</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>1 DAY</b> </td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>END STAGE MULTIPLE SCLEROSIS OVER 25 YR.</b></td> <td rowspan="2">           Due to (or as a consequence of):<br/> <b>over 25 yr</b> </td> </tr> <tr> <td>c. <b>W/ DIABETES MELLITUS, G. TUBA PARALYSIS</b></td> </tr> <tr> <td>d. <b>W/ BAD STAGE EPILEPSY</b></td> <td><b>over 2 yr</b></td> </tr> </table> |   |   |  |  |  |   |  | Immediata Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>MYOCARDIAL INFARCTION</b> | Approximate Interval Between Onset and Death<br><br><b>1 DAY</b> | Due to (or as a consequence of): |  | b. <b>END STAGE MULTIPLE SCLEROSIS OVER 25 YR.</b> | Due to (or as a consequence of):<br><b>over 25 yr</b> | c. <b>W/ DIABETES MELLITUS, G. TUBA PARALYSIS</b> | d. <b>W/ BAD STAGE EPILEPSY</b> |
| Immediata Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. <b>MYOCARDIAL INFARCTION</b>   | Approximate Interval Between Onset and Death<br><br><b>1 DAY</b>  |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | Due to (or as a consequence of):  |   |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | b. <b>END STAGE MULTIPLE SCLEROSIS OVER 25 YR.</b>  |   | Due to (or as a consequence of):<br><b>over 25 yr</b>   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   | c. <b>W/ DIABETES MELLITUS, G. TUBA PARALYSIS</b>   |   |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
| d. <b>W/ BAD STAGE EPILEPSY</b>   | <b>over 2 yr</b>  |   |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   |   |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
|   |   | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>D14221</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9.25.2000</b>  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>T. A. Fikowski 223 E. Broad Street 21221</b>   |   |   |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |   |  |   |                                 |  |                                  |  |  |   |   |                                 |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30450

|   |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedant's Name (First, Middle, Last)<br><b>BERNICE LEONA HARTLOVE</b>  |  |  |  | 2. Date of Death<br>Month <b>SEPT.</b> Day <b>22</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>9:55am</b>  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Franklin Woods Nursing Home</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |  | 4c. County of Death<br><b>Baltimore</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-36-8257</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (in yrs. last birthday)<br><b>90</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 4 1910</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>703 South Decker Ave.</b>   |  | 10f. Zip Code<br><b>21224</b>  |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:      |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+) <b>College (1-4or 5+)</b> |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>own home</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Henry Fillmore Conley</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Eva Hammack</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carroll Hartlove /son</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9624 Dundawan Road</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore Md.</b>  |  |
|   | 20d. Date<br><b>9/25/2000</b>  |  |  |  | 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex</b>  |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Anorexia</b><br>Due to (or as a consequence of):<br><b>End-stage Dementia</b><br>Due to (or as a consequence of):<br><b>Hypertension, Anemia</b> |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  | 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|   | 25. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  | 26. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Date of Injury (Month, Day, Year)<br><b>9/05</b>   |  |  |  | 28a. Time of Injury<br><b>M</b>  |  | 28b. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Franklin Square Drive, Ste 312, Baltimore, MD 21237</b>   |  |  |  | 28d. Describe how injury occurred  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br><b>T. Edmondson MD</b>  |  |  |  |
|   | 29c. License number<br><b>D45766</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>September 25, 2000</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Tom Edmondson MD 9105 Franklin Square Drive, Ste 312, Baltimore, MD 21237</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |  |  |  |
|   | 32. Registrar's Signature<br><b>B. Sparks</b>  |  |  |  | 33. State Registrar<br><b>SEP 27 2000</b>  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30451

## Certificate of Death

Reg. No.

|   |   |  |   |   |   |  |                                  |  |  |                                   |  |
|---|---|--|---|---|---|--|----------------------------------|--|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Margaret Elaine Hubbard                     |  |   |   | 2. Date of Death<br>Month: September, Day: 25, Year: 2000 |  |                                  |  | 3. Time of Death<br>5:25 am                                      |                                   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1438 East Fort Avenue |  |   |   | 4b. City, Town, or Location of Death<br>Baltimore City    |  |                                  |  | 4c. County of Death<br>N/A                                       |                                   |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-30-4502  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>66 Yrs.                 |  | If Under 1 Year<br>Months: Days: |  | If Under 24 Hrs.<br>Hours: Min.                                  |                                   |  |
|   | 8. Date of Birth (Month, Day, Year)<br>November 13, 1933                                |  | 9. Birthplace (State or Foreign Country)<br>MD  |   | 10a. State<br>MD  |  | 10b. County<br>N/A               |  | 10c. City, Town or Location<br>Baltimore City                    |                                   |  |
| Usual Residence of Decedent   |   |  |   |   |   |  |                                  |  |  |                                   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| 10e. Street and Number<br>1438 East Fort Avenue, Baltimore MD   |   |  |   | 10f. Zip Code<br>21230  |   |  |                                  | 10g. Citizen of What Country?<br>United States                                       |  |                                   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 College (1-4or 5+): 0  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Court Clerk  |   |  |                                  | 16b. Kind of Business/Industry<br>Baltimore City Court                               |  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br>Louis M. Yealldhall  |   |  |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Theresa O'Leary  |                                  |  |  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Lewis Roland Hubbard, Jr.   |   |  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1059 Locust Lane, Pasadena Maryland 21122   |                                  |  |  |                                   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Holy Cross Cem.   |   | Date<br>September 28, 2000   |                                  | 20c. Location - City or Town, State<br>Baltimore Maryland                            |  |                                   |  |
| 21. Signature of Funeral Service Licensee<br>Victor P. Doda, Jr.  |   |  |   | 22. Name and Address of Facility<br>Charles L. Stevens Funeral Home, Inc.<br>1501 East Fort Avenue, Baltimore Maryland 21230  |   |  |                                  |  |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |   |   |   |  |                                  |  |  |                                   |  |
| Immediate Cause (Final disease or condition resulting in death)   |   |  |   |   |   |  |                                  |  |  |                                   |  |
| a. Stroke   |   |  |   |   |   |  |                                  |  |  |                                   |  |
| Due to (or as a consequence of):  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| b. Atherosclerosis  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| Due to (or as a consequence of):  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| c.  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| Due to (or as a consequence of):  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| d.  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>DISTANT USE IN PAST.  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |   |   |  |                                  |  |  |                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Rheumatoid Arthritis, Peripheral Vascular Disease, Osteoporosis, Lower Leg Amputation,  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                  |  |  |                                   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |                                  |  |  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |   |  |                                  |  |  |                                   |  |
| 29b. Signature and title of certifier<br>Peter A. Holt MD   |   |  |   | 29c. License number<br>D22472   |   |  |                                  | 29d. Date signed (Month, Day, Year)<br>September 25, 2000                            |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>PETER A. HOLT MD Morgan 509 Good Samaritan Hosp Balto. md.  |   |  |   |   |   |  |                                  |  |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |   |  |   | 32. Registrar's Signature<br>Benjamin A. Sparks   |   |  |                                  |  |  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30452

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |
|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ANNA HUDSON</b>  |   | 2. Date of Death<br>Month Day Year<br><b>September 19, 2000</b>   |  | 3. Time of Death<br><b>07:50 P.M.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Bayview Medical Center</b>   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-16-5736</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>May 16, 1919</b> |
|   | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |   |   |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  |
|   | 10c. City, Town or Location<br><b>Dundalk</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|   | 10e. Street and Number<br><b>230 Robwood Road</b>   |   | 10f. Zip Code<br><b>21222</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 Years</b><br>College (1-4 or 5+) <b>Inspector</b> |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Western Electric</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Stanislaus Lansella</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Apolonia Frenczek</b>   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorothy Mach (Daughter)</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>230 Robwood Road Dundalk, Maryland 21222</b>      |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp. 9/21/2000</b>                                      |  | 20c. Location - City or Town, State<br><b>Towson, Maryland</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>                         |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Aspiration pneumonia</b><br>Due to (or as a consequence of):<br>b. <b>Mucocysts</b><br>Due to (or as a consequence of):<br>c. <b>Lymphoma</b><br>Due to (or as a consequence of):<br>d. <b>malnutrition</b> |   | Approximate Interval Between Onset and Death<br><b>3</b>  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |  |
|   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred  |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>RES0001</b>  |  |  |
|   |   | 29d. Date signed (Month, Day, Year)<br><b>September 19, 2000</b>  |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>4940 EASTERN AVENUE Baltimore Maryland 21224</b>   |   |   |   |  |  |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br>   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30453

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Barbara James

2. Date of Death

Sept. 22 2000

3. Time of Death

7:35pm

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF GLEN BURNIE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

215-01-2749

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6-9-1903

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3235 FAIT AVENUE

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

EXAMINER

16b. Kind of Business/Industry

MARLBORO SHIRT  
FACTORY

17. Father's Name (First, Middle, Last)

JOHN

JAMES

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH

(WANGER)

19a. Informant's Name/Relationship (Type, Print)

RITA STARKLAUF (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

415 POTOMAC AVENUE ROSEDALE, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK LAWN CEMETERY

Date

9/26/00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME

1211 CHESACO AVENUE ROSEDALE, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute myocardial infarction

Due to (or as a consequence of)

Approximate Interval Between Onset and Death

minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D-42521

29d. Date signed (Month, Day, Year)

September 24, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR OCHANEY

7845 Oakwood Road Suite 205 Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



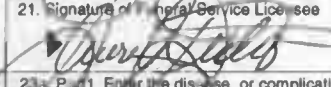
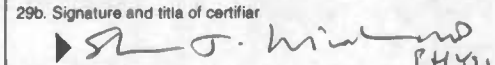
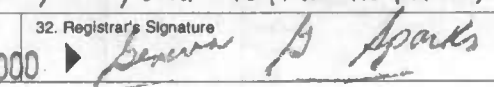
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30454

|   |   |   |  |  |  |
|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>TAE KIM</b>  |   | 2. Date of Death<br>Month Day Year<br><b>September 12 2000</b>   |  | 3. Time of Death<br><b>11:40pm</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b> |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-70-0481</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 28, 1938</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Korea</b>   |  |  |
| Usual Residence of Decedent   |   |   |  |  |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Arbutus</b>  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |  |  |
| 10e. Street and Number<br><b>1258 Circle Drive</b>  |   |   | 10f. Zip Code<br><b>21227</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian</b>   |   |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4or 5+)  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>                   |  | 16b. Kind of Business/Industry<br><b>Clothing</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Kun Ho Chong</b>  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Yong Bon Park</b>  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Chong Pae Kim - Husband</b>  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1258 Circle, Drive, Baltimore, Md. 21227</b> |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>Elkridge, Md.</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.<br/>7250 Washington Blvd., Elkridge, Md. 21075</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br><b>a. end stage liver disease</b>  |   |   |  |  | <b>2 months</b>  |
| Due to (or as a consequence of):<br><b>b. Hepatitis B</b>   |   |   |  |  | <b>10 years</b>  |
| Due to (or as a consequence of):<br><b>c.</b>   |   |   |  |  |  |
| Due to (or as a consequence of):<br><b>d.</b>   |   |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |  |  |
| 29b. Signature and title of certifier<br><br><b>PHYSICIAN</b>  |   | 29c. License number<br><b>RES-000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 12, 2000</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SHANNON J. WINAKUR, MD; JOHNS HOPKINS HOSPITAL; TOWER 110; BALTIMORE, MD 21287</b>   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30455

## Certificate of Death

Reg. No.

|   |  |   |  |   |   |  |  |  |
|---|--|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph D. Kim, M.D.</b>                         |   |  |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 23, 2000</b> |  | 3. Time of Death<br><b>13:31 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>         |  | 4c. County of Death<br><b>HOWARD</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-19-4563</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>29</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                  | 8. Date of Birth (Month, Day, Year)<br><b>03-31-1971</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|   | Usual Residence of Decedent  |   |  |   |   |  |  |  |
| 10a. State<br><b>MD.</b>  |  | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Columbia</b>  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6264 Light Point Place</b>   |  |   |  | 10f. Zip Code<br><b>21045</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Asian-Korean</b>                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>  |  |   |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Physician</b>   |   |  | 16b. Kind of Business/Industry<br><b>Hospital</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Byung Kim-father</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jennifer Suk</b>  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Byung Kim</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6264 Light Point Place, Columbia, Maryland 21045</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crestlawn Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>09-27-2000 Baltimore, Maryland</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Calvin M. Jones</i>   |  |   |  | 22. Name and Address of Facility<br><b>Witzke Funeral Home, Inc.<br/>5555 Twin Knolls Road, Columbia, Maryland 21045</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pulmonary Thromboemboli</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|   |  |   |  |   |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |   |   |  |  |  |
| 29b. Signature and title of Certifier<br><i>J.M. Kim</i>  |  |   |  | 29c. License number<br><b>OCME</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 24, 2000</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  | 32. Registrar's Signature<br><i>Benita B. Spotts</i>  |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Amend Items 20a, 20b per FH, 10/16/00db State of Maryland / Department of Health and Mental Hygiene  
amend item 5, 20b, 20c, per fh G788 10/3/00 yf

## Certificate of Death

Reg. No.

00 30456

|  |   |   |  |   |   |  |  |  |
|--|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><u>Jesse W. Kensler</u>                         |   |  |   | 2. Date of Death<br>Month <u>Sept.</u> Day <u>16</u> Year <u>2000</u> |  | 3. Time of Death<br><u>4:15 PM</u>                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><u>9413 Wandering Way</u> |   |  |   | 4b. City, Town, or Location of Death<br><u>Columbia</u>               |  | 4c. County of Death<br><u>Howard</u>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><u>216-30-5720</u><br><u>216-3-5720</u>                        |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><u>65</u> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><u>02-26-1935</u> |  |
|  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                                 |   | 10. Usual Residence of Decedent  |   | 10a. State<br><u>MD.</u>  |  | 10b. County<br><u>Howard</u>                             |  |
| 10c. City, Town or Location<br><u>Columbia</u>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><u>9413 Wandering Way</u>   |   | 10f. Zip Code<br><u>21045</u>  |  |  |
| 10g. Citizen of What Country?<br><u>USA</u>  |   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>1957 to 1983</u> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>5</u>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Retired Army Officer</u>                              |   | 16b. Kind of Business/Industry<br><u>U.S. Army</u>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><u>Jesse Kensler</u>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Charlotte Jones</u>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Nancy Kensler</u>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>9413 Wandering Way, Columbia, Maryland 21045</u>                  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Arlington National Cemetery, Arlington, VA.</u>  |  | 20c. Location - City or Town, State<br><u>Laurel, Md.</u>   |   | 20d. Date<br><u>9/10/2000</u>  |  |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>  |   | 22. Name and Address of Facility<br><u>Witzke Funeral Homes, Inc.</u><br><u>5555 Twin Knolls Drive Columbia, MD 21045</u>   |  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | a. <u>Lung Cancer</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____   |  |   |   | Approximate Interval Between Onset and Death<br><u>8 months</u>  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><u>M</u>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                       |   | 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>DL 21981</u>  |   | 29d. Date signed (Month, Day, Year)<br><u>September, 25, 2000</u>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Lloyd H. Ketchum MD</u>   |   | <u>6900 Georgia Ave NW, Washington DC 20307</u>   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><u>SEP 27 2000</u>  |   | 32. Registrar's Signature<br><u>[Signature]</u>   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 30457

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Margaret Elizabeth Lynn   |   |   |  | 2. Date of Death<br>Month Day Year<br>September 26, 2000   |  | 3. Time of Death<br>6:40AM                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Glen Meadows  |   |   |  | 4b. City, Town, or Location of Death<br>Notchcliff   |  | 4c. County of Death<br>Baltimore                                 |  |
| Funeral<br>Director   | 5. Social Security Number<br>217-24-6240  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>85 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>8/1/1915                  |  |
|   | 9. Birthplace (State or Foreign Country)<br>North Carolina  |   | 10a. State<br>Maryland  |  | 10b. County<br>Harford   |  | 10c. City, Town or Location<br>Belair                            |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br>801 Grayson Court   |  | 10f. Zip Code<br>21014   |  | 10g. Citizen of What Country?<br>USA                             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Manager                                  |  | 16b. Kind of Business/Industry<br>Retail   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Malcon Ralph Campbell  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Kathleen Clark  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>John Richard Lynn, Sr. (son)  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>801 Grayson Court Bel Air Maryland 21014  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  | 20d. Date<br>9/30/2000   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br>Bruzdinski Funeral Home PA<br>1407 Old Eastern Avenue Essex, Maryland 21221  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>urosepsis</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  | Approximate Interval Between Onset and Death<br>5 days   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Dementia</u><br><u>Breast Cancer</u>   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |   | 29c. License number<br>025205  |  | 29d. Date signed (Month, Day, Year)<br>September 27, 2000                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>W.A. Riley GARC 6701 N. Charles ST. Balto. md 21209   |   |   |   |  |  |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

11-2-1964



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30458

Amended Item#25 per PHYG787 9/27/2000 EW

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BRIAN T. LEHMAN</b>   |   | 2. Date of Death<br>Month Day Year<br><b>September 12 2000</b>   |  | 3. Time of Death<br><b>0948 pm</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b>  |   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>458-73-2565</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>16</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>5-18-1984</b>          | 9. Birthplace (State or Foreign Country)<br><b>Michigan</b>  |
|  | Usual Residence of Decedent  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Pennsylvania</b>  | 10b. County<br><b>Cumberland</b>  | 10c. City, Town or Location<br><b>Newville</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>20 Stone Ledge Road</b>   |   | 10f. Zip Code<br><b>17241</b>  |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>   |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:        |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>              |  |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>  |   | 16b. Kind of Business/Industry<br><b>Public School</b>   |  |  |
| To Be Completed by Physician/Medical Examiner  | 17. Father's Name (First, Middle, Last)<br><b>Randy L. Lehman</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Beverly Hartman</b>  |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Hoffman-Roth Funeral Home</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>219 North Hanover Street, Carlisle, Pennsylvania</b> |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Prospect Hill Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>9-16-00 Newville, Pennsylvania</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>Wallace S. Brooks, Jr.</b>   |   | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road, Towson, Md. 21204</b>  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>CNS Hemorrhage</b><br>Due to (or as a consequence of):<br>b. <b>s/p Bone Marrow Transplant</b><br>Due to (or as a consequence of):<br>c. <b>Acute Lymphocytic Leukemia</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>5 1/2 hours</b><br><b>3 weeks</b> |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>September 12, 2000</b>   |  | 28b. Time of Injury<br><b>M</b>                                  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. Signature and title of certifier<br><b>Ivor D. Berkowitz MD</b>   |  | 29c. License number<br><b>D31047</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>September 13, 2000</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ivor D. Berkowitz MD Johns Hopkins Hospital, Baltimore MD</b>   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |  | 32. Registrar's Signature<br><b>B. Spauld</b>   |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30459

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ona Bess Lee

2. Date of Death

September 22 2000

3. Time of Death

10:20 p.m.

4a. Facility Name (If not institution, give street and number)

4514 Taralee Ct

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

496-07-1347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr 10, 1916

9. Birthplace (State or Foreign Country)

Arkansas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4514 Taralee Ct.

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Oda Miller

18. Mother's Name (First, Middle, Maiden Surname)

Hattie Pearl Guinn

19a. Informant's Name/Relationship (Type, Print)

Mr. Robert E. Lee, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4514 Taralee Ct. Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery

Date

09/26/00

20c. Location - City or Town, State

Leesburg, VA

21. Signature of Funeral Service

[Signature]

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Breast Cancer to the bones

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

14 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Addison's Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D38509

29d. Date signed (Month, Day, Year)

September 25 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas J. Koutelakos 1100 S Lytle Parkway, Columbia MD 21044

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #31 PER DVR. G787 9-27-00 WR.

## Certificate of Death

Reg. No.

00 30460

|  |   |   |  |  |  |  |   |                                   |  |  |
|--|---|---|--|--|--|--|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Jean Smith McDonald</b>                              |   |  |  |  |  | 2. Date of Death<br>Month: <b>09</b> Day: <b>18</b> Year: <b>2000</b> |                                   | 3. Time of Death<br><b>3:20PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3338 G. North Chatham Road</b> |   |  |  |  |  | 4b. City, Town, or Location of Death<br><b>Ellicott City</b>          |                                   | 4c. County of Death<br><b>Howard</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>042-14-3140</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs. |  | 8. Date of Birth (Month, Day, Year)<br><b>01-01-921</b>               |                                   | 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b>                                 |  |
|  | Usual Residence of Decedent   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>                     |  | 10c. City, Town or Location<br><b>Ellicott City</b>                   |                                   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>3338 G. North Chatham Road</b>  |   | 10f. Zip Code<br><b>21042</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |   |                                   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teachers Assistant</b>  |  | 16b. Kind of Business/Industry<br><b>School System</b>   |  |  |   |                                   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Lester Smith</b>   |   |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hildur Wisting</b>   |   |                                   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathy Fuss- Daughter</b>  |   |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22 Overbrook Road, Catonsville, Maryland 21228</b>   |   |                                   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>   |  | 20c. Date<br><b>09-21-2000</b>   |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>  |   |                                   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |  |  |  | 22. Name and Address of Facility<br><b>Witzke Funeral Home, Inc.<br/>1630 Edmondson Avenue, Catonsville, Maryland 21228</b>  |   |                                   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Myocardial Infarction / Cardiac Arrest</b><br>Due to (or as a consequence of):<br>b. <b>Atherosclerotic Heart Disease</b><br>Due to (or as a consequence of):<br>c. <b>Aortic Stenosis</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>10 years</b><br><b>10 years</b> |   |   |  |  |  |  |   |                                   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Peripheral Vascular disease</b><br><b>Chronic Obstructive Pulmonary disease</b><br><b>Carotid Stenosis</b>  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |                                   |  |  |
|  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                                   |  |  |
|  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                                   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |                                   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                                   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |  |  |   |                                   |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>  |   | 29c. License number<br><b>D 19558</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>09-20-2000</b>   |  |  |   |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>716 MAIDEN CHOICE LANE</b>  |   |   |  |  |  |  |   |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>09-20-2000</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |   |                                   |  |  |

ORIGINAL

1/11/1911

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30461

|   |  |   |   |                                     |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|---|--|---|---|-------------------------------------|--|--|---|--|--|--|---|----|--------------|----------------------------------|-------|----|------------------------------|----------------------------------|-------|----|-----------|----------------------------------|-------|----|-------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Virginia Louise McArthur   |   |   |                                     | 2. Date of Death<br>Sept. 22 Day 2000 Year   |  |   |  | 3. Time of Death<br>3:55 P.M.  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Carroll County General Hospital  |   |   |                                     | 4b. City, Town, or Location of Death<br>Westminster  |  |   |  | 4c. County of Death<br>Carroll   |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| Funeral<br>Director   | 5. Social Security Number<br>481-26-0709   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                     | 7. Age (In yrs. last birthday)<br>73 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 27 1926 |  | 9. Birthplace (State or Foreign Country)<br>Iowa   |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | Usual Residence of Decedent  |   |   |                                     |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| To Be Completed by Funeral Director   | 10a. State<br>MD   |   | 10b. County<br>Carroll  |                                     | 10c. City, Town or Location<br>Taneytown   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | 10e. Street and Number<br>4719 Babylon Road  |   |   |                                     | 10f. Zip Code<br>21787   |  | 10g. Citizen of What Country?<br>USA                |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0  |   |   |                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Home Maker  |  |   | 16b. Kind of Business/Industry<br>Own Home   |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | 17. Father's Name (First, Middle, Last)<br>Richard Rhea Fain   |   |   |                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br>Flossie Flawley   |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>Stacey McArthur- Daughter  |   |   |                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4719 Babylon Road Taneytown, MD 21787   |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery   |                                     | 20c. Location - City or Town, State<br>West Des Moines Iowa  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | 21. Signature of Funeral Service Licensee<br>M. K. Marshall  |   |   |                                     | 22. Name and Address of Facility<br>Kaufman Funeral Home @ Meadowridge Memorial Park<br>7250 Washington Blvd. Ellicott City, Md 21075  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |                                     |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Septic shock</td> <td>Due to (or as a consequence of):</td> <td>1 day</td> </tr> <tr> <td>b.</td> <td>Gram negative rod septicemia</td> <td>Due to (or as a consequence of):</td> <td>1 day</td> </tr> <tr> <td>c.</td> <td>Pneumonia</td> <td>Due to (or as a consequence of):</td> <td>1 day</td> </tr> <tr> <td>d.</td> <td>Neutropenia</td> <td></td> <td></td> </tr> </table> |   |   |                                     |  |  |   |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | Septic shock | Due to (or as a consequence of): | 1 day | b. | Gram negative rod septicemia | Due to (or as a consequence of): | 1 day | c. | Pneumonia | Due to (or as a consequence of): | 1 day | d. | Neutropenia |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.   | Septic shock  | Due to (or as a consequence of):  | 1 day                               |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | b.   | Gram negative rod septicemia  | Due to (or as a consequence of):  | 1 day                               |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | c.   | Pneumonia   | Due to (or as a consequence of):  | 1 day                               |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   | d.   | Neutropenia   |   |                                     |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Metastatic breast cancer  |  |   |   |                                     |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   |  |   |   |                                     |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   |  |   |   |                                     |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                     |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M            |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |                                     |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| 29b. Signature and title of certifier<br>Howard Saintz  |  |   |   | 29c. License number<br>D15552 (Md.) |  | 29d. Date signed (Month, Day, Year)<br>9/22/00                                       |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Howard Saintz, M.D. 555 P. Center St. Westminster, Md.  |  |   |   |                                     |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |  | 32. Registrar's Signature<br>B. Sparks  |   |                                     |  |  |   |  |  |  |   |    |              |                                  |       |    |                              |                                  |       |    |           |                                  |       |    |             |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #31 PER D.V.R. G787 9-27-00 WR.

## Certificate of Death

Reg. No. 00 30462

|   |   |             |   |  |  |  |   |  |
|---|---|-------------|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Hattie Mae Merritt</b>   |             |   |  | 2. Date of Death<br>Month Day Year<br><b>September 20, 2000</b>  |  | 3. Time of Death<br><b>8:33 pm</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |             |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>220-03-9981</b>   |             | 6. Sex<br><b>1 M 2 F</b>  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>June 6, 1919</b>              |  |
|   | Usual Residence of Decedent   |             | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>   | 10b. County | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>5621 Laurelton Avenue</b>  |             |   | 10f. Zip Code<br><b>21214</b>                    |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
|   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |             | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b>       |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12 College (1-4 or 5+)</b>  |             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b> |  |  | 16b. Kind of Business/Industry<br><b>own home</b>  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Charles Augustus Carter</b>   |             |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Grace Evelyn Pearson</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Henry C. Merritt, Jr. - Husband</b>  |             |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5621 Laurelton Ave., Baltimore, MD 21214</b> |  |   |  |
|   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>                    |  | Date<br><b>9/23/00</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |  |
|   | 21. Signature of Funeral Service Licensed<br>   |             | 22. Name and Address of Facility<br><b>Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214</b>           |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>MYOCARDIAL INFARCTION</b><br><b>Hypercholesterolemia</b>  |             |   |  |  |  |   | Approximate Interval Between Onset and Death |
|   | 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |             |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>  |             |   |  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>   |             |   |  |  |  |   |  |
|   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>  |             |   |  |  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |             |   |  |  |  |   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>  |             |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |             | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>                               |  |
|   | 28d. Describe how injury occurred   |             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |             |   |  |  |  |   |  |
|   | 29b. Signature and title of certifier<br>  |             | 29c. License number<br><b>D 14 748</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>09-22-00</b>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ISSAM B CHEIKH M.D. GOOD SAMARITAN HOSPITAL BALTIMORE, MD.</b>   |             |   |  |  |  |   |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |             | 32. Registrar's Signature<br>             |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30463

|   |  |   |   |  |  |  |   |
|---|--|---|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Katherine Virginia Marsh</b>                          |   |   | 2. Date of Death<br>Month Day Year<br><b>September 22, 2000</b>  |  | 3. Time of Death<br><b>4:05 PM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Crofton Convalescent Center</b> |   |   | 4b. City, Town, or Location of Death<br><b>Crofton</b>   |  | 4c. County of Death<br><b>Anne Arundel</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-30-0231</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 9, 1911</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                 |
|   | Usual Residence of Decedent  |   |   |  |  |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>Baltimore City</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |
| 10e. Street and Number<br><b>5932 Bertram Avenue</b>  |  |   | 10f. Zip Code<br><b>21214</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                               |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Salesperson</b>   |  | 16b. Kind of Business/Industry<br><b>Retail</b>                              |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles Eldridge Waesche</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Elizabeth Riddlemoser</b>  |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth A. Jewer- Granddaughter</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>606 Moonglow Raod Odenton, MD 21113</b>   |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>9/26/00 Baltimore, MD</b>          |  |   |
| 21. Signature of Funeral Service Licensee<br><b>Paul L. Hancock Jr</b>  |  |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21214</b><br><b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>   |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Urinary Tract infection</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |  |  | Approximate interval Between Onset and Death<br><b>3 days</b>                               |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia, Malnutrition, Osteoporosis</b>   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |
|   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   |  |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner   |  |   | 29b. Signature and title of certifier<br><b>MD</b>  |  |  |  |   |
|   |  |   | 29c. License number<br><b>D38958</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/25/2000</b>                      |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Daljeet Singh Sidhu 1413 Annapolis Road #106 Odenton MD 21113</b>  |  |   |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  |   | 32. Registrar's Signature<br><b>Geneva B. Sparks</b>  |  |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30464

|   |   |   |  |  |   |                                      |   |  |   |  |   |
|---|---|---|--|--|---|--------------------------------------|---|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>James R. Myers</b>   |   |  |  | 2. Date of Death<br>Month <b>September</b> Day <b>14</b> Year <b>2000</b>   |                                      |   |  | 3. Time of Death<br><b>7:30 AM</b>                                      |  |   |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Good Samaritan Hospital</b>  |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>   |                                      |   |  | 4c. County of Death<br><b>N/A</b>                                       |  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-10-4333</b>   |   | 6. Sex<br><b>1</b> M <b>2</b> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  |                                      | 8. Date of Birth (Month, Day, Year)<br><b>March 31, 1913</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |  |   |
|   | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>N/A</b> 10c. City, Town or Location <b>Baltimore City</b> 10d. Inside City Limits <b>1</b> Yes <b>2</b> No   |   |  |  | 10e. Street and Number<br><b>6202 Marglenn Avenue</b>   |                                      |   |  | 10f. Zip Code<br><b>21206</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |
| To Be Completed by<br>Funeral Director  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |                                      |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>College (1-4or 5+)</b>   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Automobile Assembly</b>           |                                      |   |  | 16b. Kind of Business/Industry<br><b>Automobile Manufacturing</b>       |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>Robert Myers</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ora May Markel</b>  |                                      |   |  |   |  |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Margaret M. Letterman (Friend)</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2127 Southorn Road Middle River, MD 21220</b> |                                      |   |  |   |  |   |
| To Be Completed by<br>Physician/Medical Examiner  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |  | Date<br><b>9/19/2000</b>  |                                      | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                       |  |   |  |   |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.</b><br><b>7922 Wise Ave Dundalk, Maryland 21222</b>   |  |   |                                      |   |  |   |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aspiration Pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Senile Dementia</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |  | Approximate Interval Between Onset and Death  |                                      |   |  |   |  |   |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Urosepsis</b>  |   |  |  |   |                                      |   |  |   |  |   |
| Medical Certification: To Be Completed by<br>Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Urosepsis</b>  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                             |                                      |   |  |   |  |   |
|   |   |   |  |  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |  |   |  |   |
|   | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |                                      |   |  |   |  |   |
|   | 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending investigation <b>6</b> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)<br><b>M</b>  |  | 28b. Time of Injury<br><b>1</b> Yes <b>2</b> No   |                                      | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  |   |  | 28d. Describe how injury occurred                     |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br> |  |  |   | 29c. License number<br><b>D16619</b> |   | 29d. Date signed (Month, Day, Year)<br><b>September 14, 2000</b> |   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>C. Vergara-Soares M.D. 6040 Harford Road Baltimore, MD 21214</b>   |   |   |  |  |   |                                      |   |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br>             |  |  |   |                                      |   |  |   |  |   |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30465

|   |  |  |   |                                  |  |
|---|--|--|---|----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Nona Crabill Power   |  | 2. Date of Death<br>Month: September Day: 22 Year: 2000   |                                  | 3. Time of Death<br>7:11AM   |
|   | 4a. Facility Name (If not institution, give street and number)<br>711 Maiden Choice Lane   |  | 4b. City, Town, or Location of Death<br>Catonsville   |                                  | 4c. County of Death<br>Baltimore   |
| Funeral<br>Director   | 5. Social Security Number<br>577-01-7294   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>86 Yrs.   | If Under 1 Year<br>Months: Days: | 8. Date of Birth (Month, Day, Year)<br>06-30-1914  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |                                  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |  |   |                                  |  |
|   | 10a. State<br>MD   | 10b. County  | 10c. City, Town or Location<br>Baltimore  |                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
|   | 10e. Street and Number<br>717 Maiden Choice Lane   |  | 10f. Zip Code<br>21228  |                                  | 10g. Citizen of What Country?<br>USA   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Years: |                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |                                  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2 College (1-4 or 5+)   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                             |                                  | 16b. Kind of Business/Industry<br>Own Home   |
|   | 17. Father's Name (First, Middle, Last)<br>Raymond Crabill   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nona Reilly  |                                  |  |
|   | 19. Informant's Name/Relationship (Type, Print)<br>Patricia Santangelo-Daughter  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3035 Stanford Avenue, Iowa City, Iowa 52245      |                                  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cemetery   |                                  | 20c. Location - City or Town, State<br>10-03-2000 Virginia   |
|   | 21. Signature of Funeral Service Licensee<br><i>Adonia McLean</i>  |  | 22. Name and Address of Facility<br>Witzke Funeral Home, Inc.<br>1630 Edmondson Avenue, Catonsville, Maryland 21228                               |                                  |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Breast Cancer                       |  |   |                                  | Approximate Interval Between Onset and Death<br>6 years  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
|   | Due to (or as a consequence of):   |  |   |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |                                  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   |                                  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |                                  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |                                  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |                                  |  |
| 28a. Date of Injury (Month, Day, Year)  |  |  |   |                                  |  |
| 28b. Time of Injury<br>M  |  |  |   |                                  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |                                  |  |
| 28d. Describe how injury occurred   |  |  |   |                                  |  |
| 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)  |  |  |   |                                  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |                                  |  |
| 29b. Signature and title of certifier<br><i>Phillip Stone</i> MD  |  |  |   |                                  |  |
| 29c. License number<br>47009  |  |  |   |                                  |  |
| 29d. Date signed (Month, Day, Year)<br>September 22, 2000   |  |  |   |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Phillip Stone, 711 Maiden Choice Lane, Baltimore, MD 21228  |  |  |   |                                  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |  |  |   |                                  |  |
| 32. Registrar's Signature<br><i>Beverly B. Sparks</i>   |  |  |   |                                  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30466

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Flossie Gertrude Pfarr</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>Sept. 26, 2000</b>   |  | 3. Time of Death<br><b>8:15pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7022 Eastbrook Ave</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-34-7405</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 11, 1911</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>De</b>   |  | 10a. State<br><b>Md</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Dundalk</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>7022 Eastbrook Ave</b>   |  | 10f. Zip Code<br><b>21224</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 Yrs.</b> College (1-4 or 5+)                      |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>James Smith</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lottie Smith Weber</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carolyn Inks Daughter</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7022 Eastbrook Ave. Dundalk, Md. 21224</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | 20c. Location - City or Town, State<br><b>Sept 30 2000 Catonsville, Md</b>  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Anthony Connelly</b>  |  |  |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Dundalk, P.A.<br/>7110 Sollers Point Rd. Dundalk, Md. 21222</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>b. Diffuse Carcinomatosis</b><br>Due to (or as a consequence of):<br><b>c. Lung Cancer</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |  |  | Approximate Interval Between Onset and Death<br><b>6 mo.</b><br><b>1 yr.</b><br><b>2 yrs.</b>   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  | 29b. Signature and title of certifier<br><b>John V. Conway, M.D.</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D0003626</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>9/27/00</b>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John V. Conway MD, 6215 Eastern Ave, Balt, MD 21224</b>  |  |  |  | 31. Data filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><b>John V. Conway</b>  |  |  |  | 33. Registrar's Signature<br><b>John V. Conway</b>  |  |   |  |
|   | 34. Registrar's Signature<br><b>John V. Conway</b>  |  |  |  | 35. Registrar's Signature<br><b>John V. Conway</b>  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

00 30467

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>KEVIN B. PETERSON</b>                               |   |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 21, 2000</b>   |  | 3. Time of Death<br><b>21:58</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b> |   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>   |  | 4c. County of Death<br><b>Calvert</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>476-62-0764</b>  | 6. Sex<br><b>15X M</b> 2 <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth (Month, Day, Year)<br><b>April 15, 1952</b>                         |   |
|  | 9. Birthplace (State or Foreign Country)<br><b>Fargo, ND</b>                                       |   |  |   |  |  |   |
| Usual Residence of Decedent  |  |   |  |   |  |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Calvert</b>   |  | 10c. City, Town or Location<br><b>St. Leonard</b>   |  | 10d. Inside City Limits<br><b>XX</b> Yes 2 <input type="checkbox"/> No               |   |
| 10e. Street and Number<br><b>6295 Parkers Wharf Road</b>   |  |   |  | 10f. Zip Code<br><b>20685</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>Unk.</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>3</b>   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nuclear Engineer</b> |   | 16b. Kind of Business/Industry<br><b>Engineering</b> |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Duane O. Peterson</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sharon Egleston</b>   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Scott Peterson / Brother</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4327 Hadley Avenue North Oakdale MN 55128</b>   |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fairview Cemetery</b>  |  | Date<br><b>September 26, 2000</b>   |  | 20c. Location - City or Town, State<br><b>Stillwater, MN</b>                         |   |
| 21. Signature of Funeral Service Licensee<br><b>Victor P. Doda, Jr.</b>  |  |   |  | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 East Fort Avenue, Baltimore Maryland 21230</b>  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Sudden Death/ Cardiovascular Arrest</b><br>Due to (or as a consequence of):<br><b>b. coronary heart disease</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c. hyperlipidemia</b><br>Due to (or as a consequence of):<br><b>d. tobacco</b> |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1993</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Unwitnessed death; brought to ER</b><br><b>History MI + Arrhythmia 1993</b>   |  |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 <input checked="" type="checkbox"/> Yes</b> 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes</b> 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes</b> 2 <input type="checkbox"/> No  |  |   |  |  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
| 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner  |  | 29b. Signature and title of certifier<br><b>J-M. Brooks</b>   |  |   |  |  |   |
| 29c. License number<br><b>D39920</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9-22-00</b>   |  |   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. John M. Brooks, M.D. Prince Frederick, MD 20678</b>   |  |   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |  | 32. Registrar's Signature<br><b>B. Sparks</b>   |  |   |  |  |   |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 30468

|   |  |                                 |  |  |   |   |   |  |   |  |
|---|--|---------------------------------|--|--|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GAIL Rook</b>                             |                                 |  |  | 2. Date of Death<br>Month Day Year<br><b>September 24, 2000</b> |   |   |  | 3. Time of Death<br><b>8:20 PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL</b> |                                 |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>        |   |   |  | 4c. County of Death<br><b>N/A</b>                                       |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-22-4972</b>  |                                 | 6. Sex<br><b>1 M 2 F</b>   |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.                |   | 8. Date of Birth (Month, Day, Year)<br><b>July 11, 1928</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Indiana</b>              |  |
|   | Usual Residence of Decedent  |                                 |  |  | 10c. City, Town or Location                                     |   |   |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>                            |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b> |  | 10c. City, Town or Location<br><b>Lansdowne</b>  |   |   |   | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |   |  |
| 10e. Street and Number<br><b>2430 Alma Road</b>   |  |                                 |  | 10f. Zip Code<br><b>21227</b>  |   |   |   | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b> |  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><b>1 Yes 2 No</b> |   |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: White</b> |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  |                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                         |   |   |   | 16b. Kind of Business/Industry<br><b>Transportation</b>  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Floyd Rook</b>  |  |                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Unknown</b>  |   |   |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph Herold Companion</b>  |  |                                 |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2430 Alma RD. Lansdowne, MD. 21227</b>               |   |   |   |  |   |  |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  |                                 |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Ceamatory</b>   |   |   |   | 20c. Location - City or Town, State<br><b>09/26/00 Catonsville, MD.</b>                          |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |                                 |  | 22. Name and Address of Facility<br><b>Ambrose Funeral Home 1328 Sulphur Spring RD. Arbutus, MD. 21227</b>   |   |   |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. METASTASIS to BRAIN</b><br>Due to (or as a consequence of):<br><b>b. RECTAL ADENOCARCINOMA</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |                                 |  |  |   |   |   | Approximate Interval Between Onset and Death<br><b>Two months</b><br><b>Seven months</b>         |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>MITRAL REGURGITATION</b>   |  |                                 |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>   |   |   |   |  |   |  |
|   |  |                                 |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |   |  |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>   |  |                                 |  | 28. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>     |   |   |   |  |   |  |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |  |                                 |  | 28a. Date of Injury (Month, Day Year)<br><b>28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No</b>  |   |   |   | 28d. Describe how injury occurred  |   |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>  |  |                                 |  | 29c. License number<br><b>P13474</b>   |   |   |   | 29d. Date signed (Month, Day, Year)<br><b>September 24, 2000</b>                                 |   |  |
| 29b. Signature and title of certifier<br><b>Farzad Majidi Internal Medicine Resident</b>  |  |                                 |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FARZAD MAJIDI, 3001 SOUTH HANOVER ST., BALTIMORE MD 21225</b> |   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  |                                 |  | 32. Registrar's Signature<br>  |   |   |   |  |   |  |

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020





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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #31 PER DVR G787 9-27-00 WR.

## Certificate of Death

Reg. No.

00 30469

|  |   |   |  |   |  |  |   |  |   |  |
|--|---|---|--|---|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Rose Ribero</b>                                  |   |  |   | 2. Date of Death<br>Month <b>Sept.</b> Day <b>23,</b> Year <b>2000</b> |  |   |  | 3. Time of Death<br><b>3:50am</b>                             |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>6613 Windsor Mill Road</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Woodlawn</b>                |  |   |  | 4c. County of Death<br><b>Baltimore</b>                       |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-07-8199</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                       |  | 8. Date of Birth (Month, Day, Year)<br><b>07 -04-1921</b> |  | 9. Birthplace (State or Foreign Country)<br><b>New Jersey</b> |  |
|  | Usual Residence of Decedent   |   |  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>                           |  | 10c. City, Town or Location<br><b>Woodlawn</b>                |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>6613 Windsor Mill Road</b>   |  |   |  | 10f. Zip Code<br><b>21207</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>            |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |   |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b></b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cafeteria Worker</b>  |  |  |   | 16b. Kind of Business/Industry<br><b>School System</b> |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Arsenio Ippolito</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Terranova</b>  |  |  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Anita Ribero- Daughter</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6613 Windsor Mill Road, Woodlawn, Maryland 21207</b>  |  |  |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery</b>   |  | 20c. Date<br><b>09-26-2000</b>  |  | 20d. Location - City or Town, State<br><b>Baltimore, Maryland</b>                |   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Witzke Funeral Home, Inc.<br/>1630 Edmondson Avenue Catonsville, MD 21228</b>  |  |  |   |  |   |  |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Chronic Renal Failure</b><br>Due to (or as a consequence of):<br><b>Diabetes</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Hypertension</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>16 mo</b><br><b>7rs</b> |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |  |   |  |   |  |
| 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day Year)<br><b>M</b>   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how injury occurred                      |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  | 29b. Signature and title of certifier<br>   |  |  |   | 29c. License number<br><b>027310</b>                   |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>9/25/00</b>  |   |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jeffrey N. Posner M.D. 1838 Green Tree Road Balto Md 21208</b>   |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>9-25-2000</b>  |   |   |  | 32. Registrar's Signature<br>   |  |  |   |  |   |  |

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30470

|   |   |  |  |  |   |   |   |  |
|---|---|--|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Redemann</b>                           |  |  |  | 2. Date of Death<br>Month <b>SEP</b> Day <b>26</b> Year <b>2000</b> |   | 3. Time of Death<br><b>5:00 AM</b>                          |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Eastpoint Nursing Home</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>              |   | 4c. County of Death<br><b>Baltimore</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-16-5136</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                    |   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 14, 1923</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |  | 10a. State<br><b>Md</b>  |  | 10b. County<br><b>Baltimore</b>                                     |   | 10c. City, Town or Location<br><b>Dundalk</b>               |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>96 Avalon Ave</b>   |  | 10f. Zip Code<br><b>21222</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Robert Puente</b>                                       |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Puente Garcia</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruth Redemann daughter</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8209 Peach Orchard Rd. Dundalk, Md. 21222</b>  |   |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gar.</b>  |  | 20c. Location - City or Town, State<br><b>2000 Middle River, Md.</b>   |   | 21. Signature of Funeral Service Licensee<br><b>Anthony Connelly</b>                                  |   |  |
| 22. Name and Address of Facility<br><b>Connelly Funeral Home of Dundalk, P.A.<br/>7110 Sollers Point Rd. Dundalk, Md. 21222</b>   |   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CONGESTIVE HEART FAILURE</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   | 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24c. Location (Street and Number or Rural Route Number, City or Town, State)                          |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day Year)   |   |  |
| 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Matthew McNabney</b>   |   | 29c. License number<br><b>D45757</b>  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>SEP 26, 2000</b>  |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MATTHEW McNABNEY 5505 HOPKINS BAYVIEW Circle BAT MD 21224</b>   |  | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |



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State of Maryland / Department of Health and Mental Hygiene

00 30471

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DIANA L. RICHARDS

2. Date of Death

Month  
September

Day

25

Year

2000

3. Time of Death

4:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

216-36-5442

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year

JULY 7, 1937

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

8359 WB&amp;A RD.

10f. Zip Code

21144

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

RATE CLERK

16b. Kind of Business/Industry

INSURANCE

17. Father's Name (First, Middle, Last)

JAMES WATTS

18. Mother's Name (First, Middle, Maiden Surname)

IDELLA SHERMAN

19a. Informant's Name/Relationship (Type, Print)

HARRY E. RICHARDS, II/ HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8359 WB&amp;A RD., SEVERN, MARYLAND 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PK.

Date

SEPT. 29  
2000

20c. Location - City or Town, State

GLEN BURNIE, MARYLAND

21. Signature of Funeral Service licensee

22. Name and Address of Facility

KIRKLEY-RUDDICK FUNERAL HOME, P.A.  
421 CRAIN HWY., S.E., GLEN BURNIE23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

ANOXIC ENCEPHALOPATHY

a. Due to (or as a consequence of):

b. DISSEMINATED INTRAVASCULAR COAGULOPATHY

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43977

29d. Date signed (Month, Day, Year)

September 25 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Angela Olesinski, 30 Hospital Drive, Glen Burnie, MD 21061

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Richards Diana L  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

UNITED STATES OF AMERICA  
DEPARTMENT OF AGRICULTURE

UNITED STATES OF AMERICA  
DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30472

|   |   |  |   |  |  |  |   |   |
|---|---|--|---|--|--|--|---|---|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>ERIC KENDALL RUMENAP, SR.</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 24, 2000</b>  |  | 3. Time of Death<br><b>4:00 PM</b>                                      |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>56 SOUTH RITTERS LANE</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>OWINGS MILLS</b>  |  | 4c. County of Death<br><b>BALTIMORE</b>                                 |   |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-48-0940</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 22, 1949</b>             |   |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>   |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>  |  | 10c. City, Town or Location<br><b>OWINGS MILLS</b>                      |   |
| To Be Completed by Funeral Director           | Usual Residence of Decedent   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |
|   | 10e. Street and Number<br><b>56 SOUTH RITTERS LANE</b>  |  |   |  | 10f. Zip Code<br><b>21117</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |   |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>GRAVEDIGGER</b>   |  | 16b. Kind of Business/Industry<br><b>H. HUBER &amp; SON</b>  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>ROLAND GEORGE RUMENAP, SR.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ETHEL MAE SULLIVAN</b>   |  |   |   |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>LINDA RUMENAP / WIFE</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>56 SOUTH RITTERS LANE - OWINGS MILLS, MD 21117</b>                                       |  |   |   |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW CEMETERY</b>  |  | Date<br><b>9/26/00</b>   |  | 20c. Location - City or Town, State<br><b>REISTERSTOWN, MD</b>          |   |
|   | 21. Signature of Funeral Service Licensee<br><i>Jay Alton Lewis</i>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>   |  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Renal cell carcinoma, metastatic</b>  |  |   |  |  |  |   | Approximate Interval Between Onset and Death  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |  |  |   |   |
|   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                                       |   |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>Louis Miller MD</i>   |  | 29c. License number<br><b>D07421</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>9/25/00</b>  |  |   |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Louis Miller MD 1638 Grove Tree Rd #300 21208</b>  |  |   |  |  |  |   |   |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  | 32. Registrar's Signature<br><i>James B. Spauls</i>   |  |  |  |   |   |
|   | State Registrar   |  |   |  |  |  |   |   |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30473

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GARY HOWARD RUBIN</b>                                 |  |   |   | 2. Date of Death<br>Month <b>September</b> Day <b>22</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>8:40 PM</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL OF BALTIMORE</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-60-7787</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>DEC 29 1953</b>                                      |  |  |
|   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10a. Street and Number<br><b>3703 SEVEN MILE LANE APT. A-5</b>  |  |  |   | 10f. Zip Code<br><b>21208</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary</b>  |  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TRUCK DRIVER</b>  |  | 16b. Kind of Business/Industry<br><b>TRANSPORTATION</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>ALBERT RUBIN</b>  |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FREDA L. LUSTMAN</b>  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ALBERT RUBIN/FATHER</b>  |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 POMONA SOUTH APT. 9, BALTIMORE, MD. 21208</b>  |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MIKRO KODESH-BETH ISRAEL CONGREGATION</b>  |  | 20c. Location - City or Town, State<br><b>BALTIMORE, MD.</b>   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |  |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS. INC.<br/>8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>MULTISYSTEM ORGAN FAILURE</b><br>Due to (or as a consequence of):<br><b>BRAIN DEATH</b><br>Due to (or as a consequence of):<br><b>INTRACRANIAL GUNSHOT WOUND TO HEAD</b><br>Due to (or as a consequence of):<br><b>SUICIDE ATTEMPT</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br><b>ONE HOUR</b><br><b>5 HOURS</b><br><b>7 HOURS</b><br><b>7 HOURS</b>  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEPRESSION</b>   |  |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |   | 28a. Date of Injury (Month, Day, Year)<br><b>SEPTEMBER 22 2000</b>  |  | 28b. Time of Injury<br><b>unknown AM</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |  |  |   | 28d. Describe how injury occurred<br><b>Subject shot self</b>   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3703 Seven Mile Lane Apartment 5, Baltimore, Maryland</b> |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>RES 0000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 22, 2000</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARK BENNETT, MD SINAI HOSPITAL OF BALTIMORE</b>   |  |  |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  |  |   | 32. Registrar's Signature<br>   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified immediately.

RUBIN, GARY



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30474

|   |  |                    |   |   |  |   |   |  |  |  |
|---|--|--------------------|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Joseph C. Stilling, Jr.                  |                    |   |   |  |   | 2. Date of Death<br>Month: September Day: 24 Year: 2000 |  | 3. Time of Death<br>1615 <sup>0</sup>                |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St. Agnes Hospital |                    |   |   |  |   | 4b. City, Town, or Location of Death<br>Baltimore       |  | 4c. County of Death<br>N/A                           |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-64-5836   |                    | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>44 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>July 18, 1956    |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|   | Usual Residence of Decedent  |                    |   |   |  |   |   |  |  |  |
| 10a. State<br>Maryland  |  | 10b. County<br>N/A |   | 10c. City, Town or Location<br>Baltimore  |  |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br>2666 Lehman Street  |  |                    |   |   |  | 10f. Zip Code<br>21223  |   | 10g. Citizen of What Country?<br>United States   |  |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |                    | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)  |  |                    |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Disabled   |  |   | 16b. Kind of Business/Industry<br>N/A                   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph C. Stilling, Sr.  |  |                    |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia A. White  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Virginia Stilling Mother  |  |                    |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2666 Lehman St. Baltimore, MD. 21223 |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |                    |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Most Holy Redeemer Cemetery   |  | Date<br>09/28/00  |   | 20c. Location - City or Town, State<br>Baltimore, Maryland   |  |  |
| 21. Signature of Funeral Home Licensee<br>  |  |                    |   | 22. Name and Address of Facility<br>Ambrose Funeral Home 1328 Sulphur Spring Road<br>Arbutus, Maryland 21227  |  |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                    |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)   |  |                    |   |   |  |   |   |  |  | hours  |
| a. Respiratory Failure<br>Due to (or as a consequence of):  |  |                    |   |   |  |   |   |  |  | weeks  |
| b. Pneumonia<br>Due to (or as a consequence of):  |  |                    |   |   |  |   |   |  |  | months   |
| c. Lung cancer with brain metastases<br>Due to (or as a consequence of):  |  |                    |   |   |  |   |   |  |  |  |
| d.  |  |                    |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HIV (+)   |  |                    |   |   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                    |   |   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |                    |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |                    |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                    |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                    |   |   |  |   |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  |                    |   |   |  | 29c. License number<br># P14443   |   | 29d. Date signed (Month, Day, Year)<br>September 24, 2000  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Daniel M. Hardy 900 Caton Avenue, Balt. Md. 21229   |  |                    |   |   |  |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |  |                    |   | 32. Registrar's Signature<br>   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME Joseph C. Stilling, Jr.  
Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30475

|   |   |  |  |  |   |  |  |  |   |  |
|---|---|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Beryl Ann Sheahy  |  |  |  | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 24, 2000  |  |  |  | 3. Time of Death<br>11:37 A.M.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>St. Agnes Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Baltimore   |  |  |  | 4c. County of Death<br>N/A  |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-16-9519  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>79 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 31, 1921 |  | 9. Birthplace (State or Foreign Country)<br>PA  |  |
|   | Usual Residence of Decedent   |  |  |  | 10a. State<br>MD  |  | 10b. County<br>N/A                                   |  | 10c. City, Town or Location<br>Baltimore  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br>1721 Arbutus Ave.   |  |  |  | 10f. Zip Code<br>21227  |  |
|   | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) School Teacher  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>School Teacher   |  |  |  | 16b. Kind of Business/Industry<br>Education   |  |  |  | 17. Father's Name (First, Middle, Last)<br>Edmund S. Cox  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Harriet G. Becker  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Kathleen Silanskis, daughter  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>278 Riverside Dr. Pasedena, MD. 21122  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |  | 20b. Piece of Disposition (Name of cemetery, crematory or other place)<br>Baltimore National cemetery   |  |  |  | 20c. Location - City or Town, State<br>Catonsville, Maryland  |  |
|   | 21. Signature of Funeral Service Licensee<br>Joan D. L...   |  |  |  | 22. Name and Address of Facility<br>Ambrose Funeral Home 1328 Sulphur Spring RD.<br>Arbutus, MD. 21227  |  |  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Arteriosclerotic Coronary<br>Due to (or as a consequence of):<br>b. Vascular Disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |
|   | 28a. Date of Injury (Month, Day Year)   |  |  |  | 28b. Time of Injury<br>M  |  |  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |   |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                   |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  | 29b. Signature of Certifier<br>Scott Bergeson  |   |  |  | 29c. License number<br>00055849  |   |  |
| 29d. Date signed (Month, Day, Year)<br>September 24 2000  |   |  |  | 30. Name and address of person who notified cause of death (Item 23a) (Type, Print)<br>SCOTT BERGESON ST. AGNES HOSPITAL |   |  |  | 31. Date filed (Month, Day, Year)<br>SEP 27 2000                             |   |  |
| 32. Registrar's Signature<br>A. Jones   |   |  |  | 33. State Registrar  |   |  |  | 34. State Registrar  |   |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30476

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>WAYNE SCOTT</b>  |   | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 18, 2000</b>  |   | 3. Time of Death<br><b>15:31</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b>   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-60-8212</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 10, 1953</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>N/A</b>  |   | 10c. City, Town or Location<br><b>BALTIMORE</b>  |
|   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>633 N. Aisquith St. #9K</b>   |   |  |
|   | 10f. Zip Code<br><b>21202</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)                       |   |  |
| To Be Completed by Physician/Medical Examiner   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SALESMAN</b>  |   | 16b. Kind of Business/Industry<br><b>MEN'S clothing</b>  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>GATHEN PAIGE</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DELORES SCOTT</b>  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>DELORES SCOTT</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>633 N. Aisquith St. #9K BALTIMORE MD 21202</b> |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>mt. Zion Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>BALTO. MD</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Gloria Adams Jones</b>  |   | 22. Name and Address of Facility<br><b>MARSHALL W. JONES, JR., F.H.P.A.<br/>4101 Edmondson Ave. BALTO. MD 21229</b>                                |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |  |   | Approximate Interval Between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)   |   |   |  |   |  |
| e. <b>ANOXIC BRAIN INJURY</b>   |   |   |  |   | <b>3 DAYS</b>  |
| Due to (or as a consequence of):  |   |   |  |   |  |
| b. <b>CORONARY ARTERY DISEASE</b>   |   |   |  |   | <b>1 MONTH</b>   |
| Due to (or as a consequence of):  |   |   |  |   |  |
| c.  |   |   |  |   |  |
| Due to (or as a consequence of):  |   |   |  |   |  |
| d.  |   |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of injury (Month, Day, Year)  | 28b. Time of injury<br>M   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 28d. Describe how injury occurred  |
| 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |   |  |
| 29b. Signature and title of certifier<br><b>David Zaas, MD</b>  |   | 29c. License number<br><b>RES-000</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 18, 2000</b>                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID ZAAS, MD, JOHNS HOPKINS, 600 NORTH WOLFE, BALTIMORE, MARYLAND 21287</b>  |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |   | 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30477

Amended Item #8 per FHG788 10/3/2000 EW

## Certificate of Death

Reg. No.

|   |  |   |   |   |  |
|---|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>LESTER GEORGE SHEARER</b>                 |   | 2. Date of Death<br>Month <b>SEPT.</b> Day <b>26</b> Year <b>2000</b>   |   | 3. Time of Death<br><b>8:00am</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>7474 Rabon Ave.</b> |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-22-4506</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.  | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>  | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Jan 16 1924</b>                                |   | 9. Birthplace (State or Foreign Country)<br><b>PA</b>   |   |  |
| Usual Residence of Decedent   |  |   |   |   |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |  |
| 10e. Street and Number<br><b>7474 Rabon Ave.</b>  |  |   | 10f. Zip Code<br><b>21222</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Foreman Construction Worker</b> |   | 16b. Kind of Business/Industry<br><b>Building</b>  |
| 17. Father's Name (First, Middle, Last)<br><b>Jacob Shearer</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Boyd</b>  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Aileen Shearer / wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7474 Rabon Ave. Baltimore MD 21222</b>      |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>   |   | 20c. Location - City or Town, State<br><b>Rossville MD</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>   |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 MACE AVE. Baltimore Md. 21221</b>   |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. <u>Metastatic Lung Cancer</u></b><br>Due to (or as a consequence of):   |  |   |   |   | Approximate Interval Between Onset and Death<br><b>1 year</b>  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. <u></u></b><br>Due to (or as a consequence of):   |  |   |   |   |  |
| <b>c. <u></u></b><br>Due to (or as a consequence of):   |  |   |   |   |  |
| <b>d. <u></u></b><br>Due to (or as a consequence of):   |  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |  |   |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |  |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b>   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   | 28d. Describe how injury occurred  |
|   |  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |
| 29b. Signature and title of certifier<br><b>M. Purcell, Staff Physician</b>   |  | 29c. License number<br><b>019714</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>9/26/00</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL PURCELL, 7400 LANTERN AVE, BALTIMORE, MD 21229</b>   |  |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  | 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>  |   |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30478

|   |  |   |   |   |  |  |                                  |   |
|---|--|---|---|---|--|--|----------------------------------|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>JEANNE BRENNAN SARGEANT                |   |   |   | 2. Date of Death<br>Month Day Year<br>September 24, 2000 |  | 3. Time of Death<br>5:50 P.M.    |   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Gilchrist Center |   |   |   | 4b. City, Town, or Location of Death<br>Towson           |  | 4c. County of Death<br>Baltimore |   |
| Funeral<br>Director   | 5. Social Security Number<br>048-05-2083   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>81 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth (Month, Day, Year)<br>July 9, 1919  |                                  | 9. Birthplace (State or Foreign Country)<br>Connecticut |
|   | Usual Residence of Decedent  |   |   |   |  |  |                                  |   |
| 10a. State<br>Maryland  |  | 10b. County<br>Baltimore  |   | 10c. City, Town or Location<br>Towson   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |                                  |   |
| 10e. Street and Number<br>615 Chestnut Ave.   |  |   |   | 10f. Zip Code<br>21204  |  | 10g. Citizen of What Country?<br>U.S.A.  |                                  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                                  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4 years  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Journalist   |  | 16b. Kind of Business/Industry<br>Newspaper  |                                  |   |
| 17. Father's Name (First, Middle, Last)<br>Edward M. Brennan  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lillian Rowland  |  |  |                                  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Hilary Sargeant Andrews (daughter)  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093<br>1216 Clearfield Circle Lutherville, Maryland   |  |  |                                  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Crematory   |  | 20c. Location - City or Town, State<br>9-26-00 Baltimore, Maryland   |                                  |   |
| 21. Signature of Funeral Service Licensee<br>George J. Fennane  |  |   |   | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home, Inc.<br>6500 York Road Baltimore, Maryland 21212   |  |  |                                  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. ischemic Bowel disease<br>Due to (or as a consequence of):<br>b. Peripheral vascular disease<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |   |  |  |                                  |   |
| Approximate Interval Between Onset and Death<br>6 days<br>years   |  |   |   |   |  |  |                                  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                  |   |
|   |  |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                  |   |
|   |  |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |                                  |   |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |  |  |                                  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |                                  |   |
|   |  |   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |                                  |   |
|   |  |   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |  |                                  |   |
| 29b. Signature and title of certifier<br>W.A. Riley, MD   |  |   |   | 29c. License number<br>D25205   |  | 29d. Date signed (Month, Day, Year)<br>September 25, 2000  |                                  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>W.A. Riley, MD 16701 N. Charles St. Balt. md 21204  |  |   |   |   |  |  |                                  |   |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |  |   |   | 32. Registrar's Signature<br>P. Sparks  |  |  |                                  |   |

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30479

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |   |  |                                      |  |  |  |
|--|--|---|--|---|--|--------------------------------------|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br>Justine Suatoni  |  |   |  | 2. Date of Death<br>Month: Sept. 19, Day: 2000, Year: 2000  |  |                                      |  | 3. Time of Death<br>2:45pm   |  |
| 4a. Facility Name (If not institution, give street and number)<br>Brooke Grove Rehab. and Nursing Home   |  |   |  | 4b. City, Town, or Location of Death<br>Sandy Spring  |  |                                      |  | 4c. County of Death<br>Montgomery  |  |
| 5. Social Security Number<br>176-09-5529   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br>86 Yrs.   |  | If Under 1 Year<br>Months: Days:     |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 25, 1913   |  |
| 9. Birthplace (State or Foreign Country)<br>PA   |  | Usual Residence of Decedent   |  |   |  |                                      |  |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Howard   |  | 10c. City, Town or Location<br>Columbia   |  |                                      |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 10e. Street and Number<br>6334 Summergrape Way   |  |   |  | 10f. Zip Code<br>21044  |  | 10g. Citizen of What Country?<br>USA |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 Collage (1-4 or 5+): 0  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  |                                      |  | 16b. Kind of Business/Industry<br>Own Home   |  |
| 17. Father's Name (First, Middle, Last)<br>Joseph Tomayko  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Bizub   |  |                                      |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Laurene Mennel / Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6334 Summergrape Way, Columbia MD 21044  |  |                                      |  |  |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenwood Memorial Park   |  | Data<br>Sept. 22, 2000               |  | 20c. Location - City or Town, State<br>Lower Burrell, PA   |  |
| 21. Signature of Funeral Service Licensee<br>Victor P. Doda, Jr.   |  |   |  | 22. Name and Address of Facility<br>Charles L. Stevens Funeral Home, Inc.<br>1501 East Fort Avenue, Baltimore Maryland 21230  |  |                                      |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. ASPIRATION PNEUMONIA<br>Due to (or as a consequence of):<br><br>b. DYSPHAGIA<br>Due to (or as a consequence of):<br><br>c. CEREBROVASCULAR ACCIDENT<br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |   |  |                                      |  | Approximate Interval Between Onset and Death<br>DAYS<br>MONTHS<br>MONTHS   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |                                      |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |  |   |  |                                      |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |  |                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                      |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M             |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  |  |   |  | 28d. Describe how Injury occurred   |  |                                      |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br>STAFF PHYSICIAN  |  |                                      |  | 29c. License number<br>D42046  |  |
|  |  |   |  | 29d. Date signed (Month, Day, Year)<br>September 19, 2000   |  |                                      |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Grace Brooke Huffman 18100 Slade School Road Sandy Spring, Maryland 20860  |  |   |  |   |  |                                      |  |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 27 2000   |  |   |  | 32. Registrar's Signature<br>Sparks   |  |                                      |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30480

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>BRONYA ARONOVNA SHAPIRO</b>   |  | 2. Date of Death<br>Month Day Year<br><b>SEPTEMBER 23, 2000</b>   |  | 3. Time of Death<br><b>9:05 AM</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b> |  | 4c. County of Death<br><b>N/A</b>  |
| 5. Social Security Number<br><b>213-29-9322</b>  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 6, 1917</b>   |
| 9. Birthplace (State or Foreign Country)<br><b>RUSSIA</b>  |  |   |  |  |  |
| Usual Residence of Decedent  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>N/A</b>  |  |
| 10c. City, Town or Location<br><b>BALTIMORE</b>  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
| 10e. Street and Number<br><b>5715 PARK HEIGHTS AVENUE #110</b>   |  | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NURSE</b>  |  |
| 16b. Kind of Business/Industry<br><b>MEDICINE</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>AARON TUNKEL</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HANA (UNKNOWN)</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>LANA POPOK-VAUGHN / GRANDDAUGHTER</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>816 PAINTED POST COURT - BALTIMORE, MD 21208</b>  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>REISTERSTOWN, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Burton H. Levinson</i>   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Lymphoma (large cell)</b><br>Due to (or as a consequence of):<br>b. <b>Tumor lysis syndrome</b><br>Due to (or as a consequence of):<br>c. <b>CAD</b><br>Due to (or as a consequence of):<br>d. <b>Arrival fibrillation, DVT.</b> |  |   |  |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
|  |  |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |
|  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  |
|  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>A. Pokov M.D.</i>  |  | 29c. License number<br><b>DO054746</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 25, 2000</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>A. POKOV, M.D. 6821 REISTERSTOWN ROAD #206 - BALTIMORE, MD 21215</b>  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30481

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>MARGARET T. THOMAS-PURVIANCE  |  |   |  | 2. Date of Death<br>Month Day Year<br>September 23 2000  |  |  |  | 3. Time of Death<br>12:15 AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>STELLA MARIS@ MERCY HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE  |  |  |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-86-0806  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>38 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>8-3-1962                              |  | 9. Birthplace (State or Foreign Country)<br>NY   |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>MD.   |  | 10b. County<br>BALTIMORE  |  | 10c. City, Town or Location<br>RANDALLSTOWN  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>3974 RED DEER CIRCLE  |  |   |  | 10f. Zip Code<br>21133   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) -10- Collega (1-4or 5+) -0-  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>NURSING ASSISTANT   |  |  | 18b. Kind of Business/Industry<br>HEALTHCARE                     |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>JAMES THOMAS   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>CAROLYN BRADLEY   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>CAROLYN THOMAS (MOTHER)   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1113 WOODINGTON AVE. BALTIMORE, MARYLAND 21229  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>KING MEMORIAL PARK   |  | 20c. Date<br>9-28-2000   |  | 20d. Location - City or Town, State<br>BALTIMORE, MARYLAND   |  |
|  | 21. Signature of Funeral Service Licensee<br>Joseph D. Hibner   |  |   |  | 22. Name and Address of Facility<br>PHILLIPS FUNERAL HOME, P.A.<br>1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217   |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. Acquired Immunodeficiency Syndrome<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner                                    | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) hospice   |  |   |  |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  |
|  | 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
|  | 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>David Riseberg MD  |  |   |  |  |  |  |  |  |  |
| State<br>Registrar   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DAVID RISEBERG 301 ST PAUL PI BALTIMORE MD 21202  |  |   |  | 29c. License number<br>D40854  |  | 29d. Date signed (Month, Day, Year)<br>9/23/00                               |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>SEP 27 2000  |  |   |  | 32. Registrar's Signature<br>[Signature]   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30482

|  |   |   |  |  |  |   |   |  |  |
|--|---|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MALCOLM L TANT</b>                           |   |  |  | 2. Date of Death<br>Month Day Year<br><b>SEPT. 26 2000</b> |   | 3. Time of Death<br><b>0753</b>                             |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>7415 Kimbark Court</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Rosedale</b>    |   | 4c. County of Death<br><b>Baltimore</b>                     |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>242-42-3223</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.           |   | 8. Date of Birth (Month, Day, Year)<br><b>August 5 1932</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>North Carolina</b>                           |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>                            |   | 10c. City, Town or Location<br><b>Rosedale</b>              |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>7415 Kimbark Court</b>  |  | 10f. Zip Code<br><b>21237</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>                                |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5yrs</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Crane Operator</b>  |  | 16b. Kind of Business/Industry<br><b>Beth Steel</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Haywood Tant</b>  |   | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Virginia Greene</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Tant / wife</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7415 Kimbark Court Apt. K Baltimore MD 21237</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>                                       |   | 20c. Location - City or Town, State<br><b>Rossville MD</b>                 |  |
| 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>  |   | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Arteriosclerotic Cardiovascular Disease</b>             |  | Approximate Interval Between Onset and Death<br><b>15 years</b>   |   |  |  |
| Immediate Cause (Final disease or condition resulting in death)  |   | Due to (or as a consequence of):  |  | Due to (or as a consequence of):   |  | Due to (or as a consequence of):  |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   |   | Due to (or as a consequence of):  |  | Due to (or as a consequence of):   |  | Due to (or as a consequence of):  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>PHILIP MILITELLO MD Deputy</b>  |  | 29c. License number<br><b>D18667</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>September 26, 2000</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PHILIP MILITELLO MD Shock Trauma 225 Greene Baltimore Md 21201</b>  |   | 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  | 32. Registrar's Signature<br><b>Benita Sparks</b>  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

DHMH 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30483

|   |  |  |                                 |  |  |  |   |  |
|---|--|--|---------------------------------|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><u>Robert Eugene Weeks</u>   |  |                                 |  | 2. Date of Death<br>Month <u>September</u> Day <u>24</u> Year <u>2000</u>  |  | 3. Time of Death<br><u>12:30 AM</u>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>The Johns Hopkins Hospital</u>  |  |                                 |  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>   |  | 4c. County of Death<br><u>n/a</u>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><u>213-88-6722</u>  |  | 6. Sex<br><u>1</u> M <u>2</u> F |  | 7. Age (In yrs. last birthday)<br><u>39</u> Yrs.   |  | 8. Date of Birth<br>Month <u>October</u> Day <u>14</u> Year <u>1960</u>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>  |  | 10a. State<br><u>MD</u>         |  | 10b. County<br><u>Baltimore</u>  |  | 10c. City, Town or Location<br><u>Essex</u>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><u>1</u> Yes <u>2</u> No  |  |                                 |  | 10e. Street and Number<br><u>720 Eastern Blvd.</u>   |  | 10f. Zip Code<br><u>21221</u>   |  |
|   | 10g. Citizen of What Country?<br><u>USA</u>  |  |                                 |  | 11. Marital Status<br><u>1</u> Never Married <u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><u>1</u> Yes <u>2</u> No<br>If Yes, Give Year or Dates:  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> Yes <u>2</u> No Specify:   |  |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>10th</u> College (1-4 or 5+) <u>College</u> |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Carpenter</u>  |  |                                 |  | 16b. Kind of Business/Industry<br><u>Home Improvement</u>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><u>Robert E. Weeks Sr.</u>  |  |                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Mary D. Stutter</u>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Bonnie Hendershot /sister</u>   |  |                                 |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7700 Battle Grove Road Baltimore MD 21222</u>                                |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)   |  |                                 |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Metro CREMATORY Inc.</u>  |  | 20c. Location - City or Town, State<br><u>Baltimore Md.</u>   |  |
|   | 21. Signature of Funeral Service Licensee<br><u>R. Terry Connelly</u>  |  |                                 |  | 22. Name and Address of Facility<br><u>Connelly Funeral Home of Essex</u><br><u>300 WACE AVE. Baltimore Md. 21221</u>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><u>Pneumonia</u><br>Due to (or as a consequence of):<br>a. <u>Demyelinating Polyneuropathy</u><br>Due to (or as a consequence of):<br>b. <u>Multiple Myeloma</u><br>Due to (or as a consequence of):<br>c. <u></u><br>Due to (or as a consequence of):<br>d. <u></u><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                                 |  | Approximate Interval Between Onset and Death<br><u>48 hours</u><br><u>2 months</u><br><u>2 months</u>  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                 |  | 23b. Did tobacco use contribute to the cause of death?<br><u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><u>1</u> Yes <u>2</u> No   |  |                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><u>1</u> Yes <u>2</u> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><u>1</u> Yes <u>2</u> No   |  |                                 |  | 26. Place of Death (Check only one)<br>Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><u>1</u> Natural <u>5</u> Pending Investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide <u>4</u> Homicide   |  |                                 |  | 28a. Date of Injury (Month, Day Year)<br><u></u>   |  | 28b. Time of Injury<br><u>M</u>   |  |
|   | 28c. Injury et Work?<br><u>1</u> Yes <u>2</u> No   |  |                                 |  | 28d. Describe how injury occurred  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                 |  | 29b. Signature and title of certifier<br><u>Wen-jen Hsieh, M.D.</u>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><u>D52257</u>   |  |                                 |  | 29d. Date signed (Month, Day, Year)<br><u>September 24, 2000</u>   |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>Wen-jen Hsieh, 1650 Orleans St., Baltimore, MD 21231</u>  |  |                                 |  | 31. Date filed (Month, Day, Year)<br><u>SEP 27 2000</u>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br><u>Beverly Sparks</u>   |  |                                 |  | 33. Date of Death (Month, Day, Year)<br><u>SEP 27 2000</u>   |  |   |  |
|   | 34. State Registrar<br><u>SEP 27 2000</u>  |  |                                 |  | 35. Original   |  |   |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30484

## Certificate of Death

Reg. No.

|   |  |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|---|--|---|---|--|--|--|--|--|---|----|---------------------------------|---------|----------------------------------|--|--|----|---|---------|----------------------------------|--|--|--|----|--|--|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MATHILDE MARIE WILHELMINE WARNER   |   |   |  | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 24, 2000   |  | 3. Time of Death<br>10:15 PM   |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>210 THIRD AVE. S.E.  |   |   |  | 4b. City, Town, or Location of Death<br>GLEN BURNIE  |  | 4c. County of Death<br>ANNE ARUNDEL  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| Funeral<br>Director   | 5. Social Security Number<br>212-12-4512   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>88 Yrs.   | If Under 1 Year<br>Months Days             | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month Day Year<br>MAR. 25, 1912  |  | 9. Birthplace (State or Foreign Country)<br>MARYLAND |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | Usual Residence of Decedent  |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| To Be Completed by Funeral Director   | 10a. State<br>MARYLAND   | 10b. County<br>ANNE ARUNDEL   |   | 10c. City, Town or Location<br>GLEN BURNIE |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | 10e. Street and Number<br>210 THIRD AVE. S.E.  |   |   | 10f. Zip Code<br>21061                     |  | 10g. Citizen of What Country?<br>UNITED STATES   |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                                   |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>BOOKKEEPER                               |  |  | 16b. Kind of Business/Industry<br>FLORIST  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | 17. Father's Name (First, Middle, Last)<br>WILHELM BORKMAN   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>BERTHA REX  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>JANET PULSIFER / DAUGHTER  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>209 SECOND AVE. S.E. GLEN BURNIE, MD 21061  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GLEN HAVEN MEM. PK.   |  | Date<br>SEPT. 28, 2000   |  | 20c. Location - City or Town, State<br>GLEN BURNIE, MD   |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | 21. Signature of Funeral Service Licensee<br>► <i>Russell Deluca</i>   |   |   |  | 22. Name and Address of Facility<br>KIRKLEY-RUDDICK FUNERAL HOME P.A.<br>421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061   |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Metastatic Lung Cancer to Brain</td> <td>1 Month</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td>Broncho alveolar Cell Carcinoma of the Lung</td> <td>3 years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | a. | Metastatic Lung Cancer to Brain | 1 Month | Due to (or as a consequence of): |  |  | b. | Broncho alveolar Cell Carcinoma of the Lung | 3 years | Due to (or as a consequence of): |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | c. |  |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)   | a.   | Metastatic Lung Cancer to Brain   | 1 Month   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | b.   | Broncho alveolar Cell Carcinoma of the Lung   | 3 years   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | c.   |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   | d.   |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                    |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| 29b. Signature and title of certifier<br>► <i>Russell Deluca</i>  |  |   |   | 29c. License number<br>D31551              |  | 29d. Date signed (Month, Day, Year)<br>SEPTEMBER 25, 2000  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>RUSSELL DELUCA M.D. 1600 CRAIN HWY. GLEN BURNIE, MD 21061 SUITE 602   |  |   |   |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br>SEP 27 2000   |   | 32. Registrar's Signature<br>► <i>Russell Deluca</i>  |  |  |  |  |  |   |    |                                 |         |                                  |  |  |    |   |         |                                  |  |  |  |    |  |  |    |  |



ADH

GEORGE K. WADE

00-5308-005

amend item 7,8; per fh G787 9/27/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 30485

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|  |  |   |                                |  |  |
|--|--|---|--------------------------------|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>George K. Wade</b>  |  | 2. Date of Death<br>Month <b>SEPTEMBER</b> Day <b>19</b> Year <b>2000</b>   |                                | 3. Time of Death<br><b>4:10 P.M.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>7709 QUEEN ANNE DRIVE</b>   |  | 4b. City, Town, or Location of Death<br><b>PARKVILLE</b>  |                                | 4c. County of Death<br><b>BALTIMORE</b>  |  |
| 5. Social Security Number<br><b>214-26-6033</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>02/03/1926</b> |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |   |                                |  |  |
| Usual Residence of Decedent  |  |   |                                |  |  |
| 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Parkville</b>   |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>7709 Queen Anne Drive</b>   |  | 10f. Zip Code<br><b>21234</b>   |                                | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |                                |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Operator</b>   |                                | 16b. Kind of Business/Industry<br><b>Black and Decker</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Lee Wade</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anita Ewell</b>   |                                |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Wade Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7709 Queen Anne Dr. Baltimore, MD 21234</b>   |                                |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Balto-Wash Creamtory</b>   |                                | 20c. Location - City or Town, State<br><b>09/25 Laurel, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Bradley Ashton Matthews Funeral Home, Inc.<br/>2134 Willow Spring RD BALTIMORE, MD 21222</b>   |                                |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Intra-Oral Shotgun Wound</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | Approximate Interval Between Onset and Death  |                                |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular disease</b><br><b>Dementia</b>  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |                                |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |                                |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>9-19-00</b>  |                                | 28b. Time of Injury<br><b>1610</b> M   |  |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how Injury occurred<br><b>self-inflicted shotgun wound</b>  |                                |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>7709 Queen Anne Drive<br/>BALTIMORE, MARYLAND 21234</b>  |                                |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>   |                                | 29c. License number<br><b>OCME</b>   |  |
| 29d. Date signed (Month, Day, Year)<br><b>SEPTEMBER 20, 2000</b>   |  |   |                                |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chuteau 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |                                |  |  |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>  |  | 32. Registrar's Signature<br>   |                                |  |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30486

|   |  |   |   |                                      |  |   |  |   |
|---|--|---|---|--------------------------------------|--|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Paul Welch</b>   |   |   |                                      | 2. Date of Death<br>Month Day Year<br><b>September 23, 2000</b>  |   | 3. Time of Death<br><b>2:30 AM</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Little Sisters of the Poor</b>  |   |   |                                      | 4b. City, Town, or Location of Death<br><b>Catonsville</b>   |   | 4c. County of Death<br><b>Baltimore</b>  |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>539-46-1241</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>July 9, 1912</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Washington</b> |
|   | Usual Residence of Decedent  |   |   |                                      |  |   |  |   |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>Baltimore</b>   |                                      | 10c. City, Town or Location<br><b>Catonsville</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>603 Maiden Choice Lane</b>  |   |   |                                      | 10f. Zip Code<br><b>21228</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>  |   | College (1-4 or 5+)<br><b>5+</b>  |                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Roman Catholic Priest</b>  |   | 16b. Kind of Business/Industry<br><b>Church</b>  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Lee Welch</b>  |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Lavinia Hoose</b>   |   |  |   |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Associated Sulpicians of the US</b>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5408 Roland Avenue Baltimore, Maryland 21210</b>   |   |  |   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sulpician Cemetery</b>   |                                      | Date<br><b>9-27-00</b>   |   | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                    |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Paul L. Hancock Jr.</b>  |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21214</b><br><b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>                             |                                      |  |   |  |   |
|   | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Congestive heart failure</b><br>Due to (or as a consequence of):<br><b>b. Hypertension</b><br>Due to (or as a consequence of):<br><b>c. Arterio Sclerotic Cardio Vascular Disease</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |   |                                      |  |   |  |   |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |                                      |  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |                                      |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred                             |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Dr. Karan</b>   |   | 29c. License number<br><b>021649</b> |  | 29d. Date signed (Month, Day, Year)<br><b>Sep 25, 2000</b>  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SAM BANDAM BASKARAN 3455 WILKENS AVE. BALTIMORE. MD 21249</b>  |  |   |   |                                      |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 27 2000</b>   |  | 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>  |   |                                      |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30487

|  |  |  |   |   |  |                                  |  |
|--|--|--|---|---|--|----------------------------------|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Charles H. Wills   |  |   | 2. Date of Death<br>Month Day Year<br>September 22 2000 |  | 3. Time of Death<br>9:28pm       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Franklin Square Hospital Center  |  |   | 4b. City, Town, or Location of Death<br>Bosedale        |  | 4c. County of Death<br>Baltimore |  |
| Funeral<br>Director                              | 5. Social Security Number<br>220-01-2633   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>79 Yrs.  |                                  | 8. Date of Birth (Month, Day, Year)<br>Oct. 18, 1920                                 |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10a. State<br>Maryland  |   | 10b. County<br>Baltimore   |                                  | 10c. City, Town or Location<br>Edgemere  |
| To Be Completed by<br>Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>2610 Maseth Avenue  |   | 10f. Zip Code<br>21219   |                                  | 10g. Citizen of What Country?<br>United States                                       |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10 Years   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Steel Worker   |   | 16b. Kind of Business/Industry<br>Steel Industry   |                                  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Walter W. Wills   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rose Marie Frazier   |   |  |                                  |  |
| To Be Completed by<br>Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Catherine E. Wills (Wife)   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2610 Maseth Ave. Edgemere, Maryland 21219  |   |  |                                  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gardens of Faith Cem. 9/26/2000   |   | 20c. Location - City or Town, State<br>Baltimore, Maryland   |                                  |  |
| To Be Completed by<br>Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222   |   |  |                                  |  |
|  | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. metastatic poorly differentiated Lung carcinoma<br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |  | Approximate Interval Between Onset and Death  |   |  |                                  |  |
| To Be Completed by<br>Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>abdominal aortic aneurysm repair, mitral valve replacement<br>chronic obstructive pulmonary disease, hypertension,<br>atrial fibrillation, hyperlipidemia  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |  |                                  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |                                  |  |
| To Be Completed by<br>Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |                                  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| To Be Completed by<br>Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br>Jan Baker MD   |   |  |                                  |  |
| To Be Completed by<br>Physician/Medical Examiner | 29c. License number<br>KD192732  |  | 29d. Date signed (Month, Day, Year)<br>09/22/00   |   |  |                                  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR Lance Barker 9000 Franklin Square Drive Baltimore MD 21287  |  |   |   |  |                                  |  |
| State<br>Registrar                               | 31. Date filed (Month, Day, Year)<br>SEP 27 2000   |  | 32. Registrar's Signature<br>   |   |  |                                  |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30488

|  |  |                                |  |   |   |                          |                                |   |  |  |  |  |   |  |  |
|--|--|--------------------------------|--|---|---|--------------------------|--------------------------------|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Bennie Arnett Jr                       |                                |  |   | 2. Date of Death<br>Month Day Year<br>SEPTEMBER 7, 2000 |                          |                                |   | 3. Time of Death<br>16:58 PM           |  |  |  |   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>6925 ADEL STREET |                                |  |   | 4b. City, Town, or Location of Death<br>SEAT PLEASANT   |                          |                                |   | 4c. County of Death<br>PRINCE GEORGE'S |  |  |  |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>578-64-4978   |                                | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>50 Yrs.               |                          | If Under 1 Year<br>Months Days |   | If Under 24 Hrs.<br>Hours Min.         |  | 8. Date of Birth<br>(Month, Day, Year)<br>Oct 15, 1949 |  | 9. Birthplace (State or Foreign Country)<br>Washington DC |  |  |
|  | Usual Residence of Decedent  |                                |  |   |   |                          |                                |   |  |  |  |  |   |  |  |
| 10a. State<br>MD   |  | 10b. County<br>Prince George's |  | 10c. City, Town or Location<br>Seat Pleasant  |   |                          |                                |   |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |  |
| 10e. Street and Number<br>6925 Adel Street   |  |                                |  | 10f. Zip Code<br>20743  |   |                          |                                | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |  |   |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  |                                |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   |                          |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |   |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |                                |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br>Plaster   |   |                          |                                | 16b. Kind of Business/Industry<br>Private   |  |  |  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Bennie Arnett Sr  |  |                                |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lula Minor   |   |                          |                                |   |  |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Belinda Arnett- Sister   |  |                                |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4436 68th Place #D4 Landover Hills MD 20784  |   |                          |                                |   |  |  |  |  |   |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lincoln Memorial  |   |                          |                                | Date<br>9-16-00   |  | 20c. Location - City or Town, State<br>Suitland, Maryland  |  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |                                |  | 22. Name and Address of Facility<br>J.B. Jenkins Funeral Home<br>7474 Landover Rd Landover MD 20785   |   |                          |                                |   |  |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Dilated Cardiomyopathy<br>b. in association with Chronic<br>c. Alcoholism<br>d.<br><br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |                                |  |   |   |                          |                                |   |  |  |  |  |   | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                |  |   |   |                          |                                |   |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                |  |   |   |                          |                                |   |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) SCENE |   |                          |                                |   |  |  |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |                                |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred  |  |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |                                |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                          |                                |   |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |                                |  |   |   |                          |                                |   |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  |                                |  | 29c. License number<br>O.C.M.E.   |   |                          |                                | 29d. Date signed (Month, Day, Year)<br>SEPTEMBER 8, 2000  |  |  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201   |  |                                |  |   |   |                          |                                |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 12 2000   |  |                                |  | 32. Registrar's Signature<br>   |   |                          |                                |   |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30489

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John R. Allen

2. Date of Death  
Month Day Year  
September 5, 20003. Time of Death  
11:42 P.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-12-9040

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9/18/15

9. Birthplace (State or Foreign Country)

Croom, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

602 Cedarleaf Avenue

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Driver

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Charles Allen

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Cook

19a. Informant's Name/Relationship (Type, Print)

Agnes M. Allen/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

602 Cedarleaf Ave., Seat Pleasant, Md. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Mem. Park

Date

9/12/00

20c. Location - City or Town, State

Landover, Md.

21. Signature of Funeral Service Licensee

Aug. W. Crato

22. Name and Address of Facility

H.S. Washington &amp; Sons Co., Inc.

4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. HYPERTENSIVE CARDIOVASCULAR DISEASE  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Phillip L. L. L.

29c. License number

D27 577

29d. Date signed (Month, Day, Year)

SEPTEMBER 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ophnell Cumberbatch, M.D. 8416 Central Avenue, Landover, Md. 20785

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30490

AMENDED ITEM# 23b per physG792 022701 SS

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward T. Artin, Sr.

2. Date of Death  
Month Day Year  
September 8, 20003. Time of Death  
6:25 AM

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

280-24-5963

6. Sex

M 2 F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 29, 1927

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

Yes 2 No

10e. Street and Number

1705 Hunt Meadow Dr.

10f. Zip Code

21403

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates: 1944-1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Cement Mason

16b. Kind of Business/Industry

Cement Contracting

17. Father's Name (First, Middle, Last)

John Artin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Gonda

19a. Informant's Name/Relationship (Type, Print)

Donna J. Artin/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1705 Hunt Meadow Dr. Annapolis, Maryland 21403

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Ft. Lincoln Crematory

Date

9/11/00

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Todd E. Liller

22. Name and Address of Facility

John M. Taylor Funeral Home

147 Duke of Gloucester St. Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End stage Congestive Heart Failure

Due to (or as a consequence of):

b. Dilated Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Known positive urinary tract infection

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Unknown 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Elizabeth M. Kingsley MD

29c. License number

MD 22507

29d. Date signed (Month, Day, Year)

9-8-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAMC 64 FRANKLIN ST. Annapolis, MD 21401

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 30491

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Felix Edward Baker, Sr.

2. Date of Death

Month Day Year  
Sept. 9, 2000

3. Time of Death

0210

4a. Facility Name (If not Institution, give street and number)

Westminster Nursing &amp; Rehabilitation

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

215-05-5801

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

101 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Apr 27, 1899

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Carroll10c. City, Town or Location  
Westminster

10d. Inside City Limits

M Yes ☒ No ☐

10e. Street and Number

102 Timber Ridge Dr. Apt 216

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1918

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Janitorial

17. Father's Name (First, Middle, Last)

Harmon Jones Baker

18. Mother's Name (First, Middle, Maiden Surname)

Martha C. Ramsey

19a. Informant's Name/Relationship (Type, Print)

Myra Corbitt Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3121 Arters Mill Rd. Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cem.

Date

9-11

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Pritts Funeral Home and Chapel, P.A.

412 Washington Rd. Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Pancreatitis

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

25 days

b.

Pneumonia

Due to (or as a consequence of):

20 days

c.

Sepsis

Due to (or as a consequence of):

2 days

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

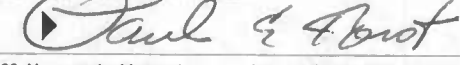
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D33281

29d. Date signed (Month, Day Year)

9/11/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PAUL E. FOREST, MD 912 Washington Rd. Westminster, Md. 21157

31. Date filed (Month, Day, Year)

SEP 12 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 30492

## Certificate of Death

Reg. No.

|   |  |                                      |   |   |  |  |  |   |
|---|--|--------------------------------------|---|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Frank George Bower</b>                          |                                      |   |   | 2. Date of Death<br>Month <b>September</b> Day <b>14</b> Year <b>2000</b>  |  | 3. Time of Death<br><b>6:00 a.m.</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4625 Piney Creek Road</b> |                                      |   |   | 4b. City, Town, or Location of Death<br><b>Taneytown</b>   |  | 4c. County of Death<br><b>Carroll County</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>188-12-2877</b>  |                                      | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>79 Yrs.</b>  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 17, 1921</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |
|   | Usual Residence of Decedent  |                                      |   |   |  |  |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Carroll County</b> |   | 10c. City, Town or Location<br><b>Taneytown</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
| 10e. Street and Number<br><b>4625 Piney Creek Road</b>  |  |                                      |   | 10f. Zip Code<br><b>21787</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+)  |  |                                      |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>carpenter</b>                     |  | 16b. Kind of Business/Industry<br><b>carpentry</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>Frank B. Bower</b>  |  |                                      |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Schmidt</b>   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>G. Samuel Bower / son</b>  |  |                                      |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4675 Piney Creek Road Taneytown, MD 21787</b> |  |  |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematorium</b>   |   | Date<br><b>Sep. 15 2000</b>  | 20c. Location - City or Town, State<br><b>Smithsburg, Maryland</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br><i>Alan C. Surin</i> M01072  |  |                                      |   | 22. Name and Address of Facility<br><b>Skiles Funeral Home</b><br><b>136 East Baltimore Street Taneytown, MD 21787</b>                            |  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>ISCHEMIC CARDIOMYOPATHY</b><br>Due to (or as a consequence of):<br>b. <b>ATHEROSCLEROTIC CORONARY HEART DISEASE</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |                                      |   |   |  |  |  | Approximate Interval Between Onset and Death<br><b>MONTHS</b><br><b>YEARS</b>   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ESSENTIAL HYPERTENSION</b>   |  |                                      |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |  |                                      |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |                                      | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|   |  |                                      | 28d. Describe how injury occurred   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |
|   |  |                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                      | 29b. Signature and title of certifier<br><i>Vincent J. Fiocco, Jr. MD</i>   |   |  | 29c. License number<br><b>DO1663</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>9/14/00</b>   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Vincent J. Fiocco, Jr., M.D. 906-C Washington Road, Westminster, MD 21157</b>  |  |                                      |   |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>SEP 14 2000</b>   |  |                                      | 32. Registrar's Signature<br><i>Benita B Sparks</i>   |   |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30493

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM BRACEY

2. Date of Death

Month  
AUGUST

Day

23,

Year

2000

3. Time of Death

6:15 AM

4a. Facility Name (If not institution, give street and number)

HEARTLAND HEALTHCARE CENTER

4b. City, Town, or Location of Death

HYATTSVILLE

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

226-12-7697

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

MARCH 29 1918

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

D.C.

10b. County

--

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1855 KENDALL ST., N.E. #1

10f. Zip Code

20002

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8TH

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SHOE REPAIRMAN

16b. Kind of Business/Industry

SHOE REPAIR

17. Father's Name (First, Middle, Last)

WILLIE BRACEY

18. Mother's Name (First, Middle, Maiden Surname)

MARY BRACEY

19a. Informant's Name/Relationship (Type, Print)

DAMITA BRACEY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1855 KENDALL ST., NE #1 WASHINGTON, DC 20002

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NAT'L CEMETERY

Date

9-1-00

20c. Location - City or Town, State

ARLINGTON, VA

21. Signature of Funeral Service Licensee

Larry Coffee

22. Name and Address of Facility

CAPITOL MORTUARY, INC.

1425 MARYLAND AVE., NE WASH., DC 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 DAYS

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dysphagia

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Diabetes Mellitus Type II

Arteriosclerotic Cardiovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Paul A. DeVore

29c. License number

D01852

29d. Date signed (Month, Day, Year)

AUGUST 23, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Paul A. DeVore, M.D. 4203 Queensbury Road Hyattsville, Md. 20781

31. Date filed (Month, Day, Year)

SEP 13 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



4



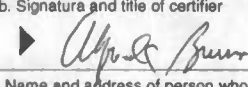
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30494

|  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Bess</b>                         |   |  |  | 2. Date of Death<br>Month Day Year<br><b>September 1, 2000</b> |  | 3. Time of Death<br><b>9:26 AM</b>                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>3315 26th Ave</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Temple Hills</b>    |  | 4c. County of Death<br><b>Prince George</b>                |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>245-28-1563</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.               |  | 8. Date of Birth (Month, Day, Year)<br><b>May 23, 1926</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Lincolnton NC</b>                       |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Prince George</b>                            |  | 10c. City, Town or Location<br><b>Temple Hills</b>         |  |  |
| Usual Residence of Decedent  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3315 26th Avenue</b>  |  | 10f. Zip Code<br><b>20748</b>  |  | 10g. Citizen of What Country?<br><b>United States of America</b> |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>8th</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |  | 16b. Kind of Business/Industry<br><b>DC Government</b>   |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Russell Bess</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Clara Finger</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Artis Bess/Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3315 26th Ave Temple Hills, MD 20748</b> |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>9/7/2000 Landover MD</b>   |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Robert G. Mason Funeral Home</b><br><b>1661 Good Hope Rd SE, Wash DC 20020</b>   |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | a. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br>b. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Due to (or as a consequence of):  |  | Approximate Interval Between Onset and Death   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No      |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of injury<br>M   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>12300</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>September 5, 2000</b>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alfred C. Burris</b>  |  | 31. Date filed (Month, Day, Year)<br><b>SEP 13 2000</b>   |  | 32. Registrar's Signature<br>   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30495

|   |  |  |   |  |   |  |  |  |  |  |
|---|--|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Lillian Battee   |  |   |  | 2. Date of Death<br>Month: September, Day: 6, Year: 2000  |  |  |  | 3. Time of Death<br>12:35AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Prince George's Hospital Center  |  |   |  | 4b. City, Town, or Location of Death<br>Cheverly  |  |  |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>578-24-4700-A   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>82 Yrs.   |  | If Under 1 Year<br>Months: Days:               |  | 8. Date of Birth (Month, Day, Year)<br>August 21, 1908   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.   |  | 10a. State<br>Maryland  |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Capitol Heights |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br>7012 Fresno Street   |  |   |  | 10f. Zip Code<br>20743  |  |  |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |
| To Be Completed by Funeral Director           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cook   |  |  |  | 16b. Kind of Business/Industry<br>Montgomery County School Board   |  |
|   | 17. Father's Name (First, Middle, Last)<br>John Scott  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Wilhelmina Coleman   |  |  |  |  |  |
| To Be Completed by Funeral Director           | 19a. Informant's Name/Relationship (Type, Print)<br>Lillian V. Riley (Daughter)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3710 Castle Terrace Silver Spring, Maryland 20904  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory, Inc.  |  |  |  | 20c. Location - City or Town, State<br>9/12/2000 Beltsville, Maryland  |  |
| To Be Completed by Funeral Director           | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |  | 22. Name and Address of Facility<br>ROLLINS FUNERAL HOME, INC.<br>4339 HUNT PLACE, N.E. WASHINGTON, D.C. 20019  |  |  |  |  |  |
|   | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Postop multiple myeloma</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>8 weeks   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |  |  |  |
|   |  |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>M 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  | 28d. Describe how Injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |  | 29c. License number<br>041715  |  |
|   |  |  |   |  | 29d. Date signed (Month, Day, Year)<br>9-3-00   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>CHITRA VENKATARAMAN MD 6201 GREENBELT ROAD U#03 COLLEGE PARK MD 20740  |  |   |  |   |  |  |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>SEP 14 2000   |  |   |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

9/28/00 amend item 27,28d per me G788 10/17/00 yr  
 amend item 23a,pt.II, 27,28a,b,c,d,e,f per me G787 yr

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 30496

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Paula Maria Bickford                             |   | 2. Date of Death<br>Month Day Year<br>September 12, 2000   |  | 3. Time of Death<br>9:05 pm             |
|   | 4a. Facility Name (If not Institution, give street and number)<br>15302 Diamond Cove Terrace |   | 4b. City, Town, or Location of Death<br>Rockville  |  | 4c. County of Death<br>Montgomery       |
| Funeral<br>Director   | 5. Social Security Number<br>213-66-2746   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>45 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.          |
|   | 8. Date of Birth (Month, Day, Year)<br>Oct. 6, 1954  |   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |
| Usual Residence of Decedent   |  |   |  |  |   |
| 10a. State<br>Maryland  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Rockville   |   |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |   |
| 10e. Street and Number<br>15302 Diamond Cove Terrace  |  |   | 10f. Zip Code<br>20850   |  | 10g. Citizen of What Country?<br>U.S.A. |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |   |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home   |   |
| 17. Father's Name (First, Middle, Last)<br>David Lawrence Satterfield   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Kathy Bernadette Thomas   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Edward E. Bickford, Jr. - Husband   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15302 Diamond Cove Terr., Rockville, MD 20850 |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery   |  | 20c. Location - City or Town, State<br>9/16/2000 Brentwood, Maryland   |   |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br>Gasch's Funeral Home, P.A.<br>4739 Baltimore Ave., Hyattsville, MD 20781  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. MIXED DRUG INTOXICATION<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |   |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene |  |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br>found: 9/12/00  |  | 28b. Time of Injury<br>unknown M   |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br>drugs unknown subject injected   |  |  |   |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>found: home   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>15302 Diamond Cove Terrace, Rockville, Montgomery County MD.  |  |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br>O.C.M.E.   |  | 29d. Date signed (Month, Day, Year)<br>September 18, 2000  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Stephen S. Radentz, 111 Penn Street, Baltimore, MD 21201  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br>SEP 19 2000  |  | 32. Registrar's Signature<br>   |  |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30497

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Milwe Horn Braddy

2. Date of Death

Month

Day

Year

September 19, 2000

3. Time of Death

11:35 PM

4a. Facility Name (If not institution, give street and number)

5006 Nash Street

4b. City, Town, or Location of Death

Capitol Heights

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

578-38-1327

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

Sept. 22, 1910

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5006 Nash Street

10f. Zip Code

20743

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodial

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Benjamin Horn

18. Mother's Name (First, Middle, Maiden Surname)

Louise Moody

19a. Informant's Name/Relationship (Type, Print)

Mattie M. Baltimore - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5006 Nash St., Capitol Heights, MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

9/15/2000

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Salvador Sylvestre, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

September 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvestre, 3001 Hospital Drive, Chevy Chase, Maryland 20785

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30498

|   |  |  |   |  |  |
|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Robert Murphy Bell   |  | 2. Date of Death<br>Month Day Year<br>September 14, 2000  |  | 3. Time of Death<br>10:50AM  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Southern Maryland Hospital   |  | 4b. City, Town, or Location of Death<br>Clinton   |  | 4c. County of Death<br>Prince George's   |
| Funeral<br>Director   | 5. Social Security Number<br>577-24-0925   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>77 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>July 14, 1923 | 9. Birthplace (State or Foreign Country)<br>Washington DC  |
|   | Usual Residence of Decedent  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br>Maryland   | 10b. County<br>Prince George's   | 10c. City, Town or Location<br>Suitland   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br>2514 Fairhill Drive  |  | 10f. Zip Code<br>20746  |  | 10g. Citizen of What Country?<br>U.S.A.  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1943-1945 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A                                     |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sheet Metal Worker  |  | 16b. Kind of Business/Industry<br>Pierce Associates   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Murphy Bell   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Myrtle Milstead  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Katherine Ann Bell (Wife)  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2514 Fairhill Drive Suitland, Maryland 20746                   |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  | 20c. Location - City or Town, State<br>Suitland, Maryland  |
|   | 21. Signature of Funeral Service Licensee<br>J. S. Sitt  |  | 22. Name and Address of Facility Lee Funeral Home, Inc.<br>6633 Old Alexandria Ferry Road Clinton, MD 20735   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Recurrent Lymphoma<br>b. Respiratory Failure<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>8 years<br>4 days |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |   |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)   |  |  |   |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |  |  |
| 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |   |  |  |
| 28d. Describe how injury occurred   |  |  |   |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and manner stated.<br>2 <input type="checkbox"/> Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |
| 29b. Signature and title of certifier<br>Harry Katz   |  |  |   |  |  |
| 29c. License number<br>D20352   |  |  |   |  |  |
| 29d. Date signed (Month, Day, Year)<br>9/15/00  |  |  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Harry Katz 8926 Woodland Rd Clinton, MD   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br>SEP 15 2000  |  |  |   |  |  |
| 32. Registrar's Signature<br>B. Sparks  |  |  |   |  |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30499

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Barnett Jr

2. Date of Death

Month Day Year  
September 12, 2000

3. Time of Death

6:30AM

4a. Facility Name (If not institution, give street and number)

246 Friendship Road

4b. City, Town, or Location of Death

Friendship

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

220-03-0730

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 21, 1912

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Friendship

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

246 Friendship Road

10f. Zip Code

20758

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
3

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Richard Barnett Sr

18. Mother's Name (First, Middle, Maiden Surname)

Cora Elsie Wilkerson

19a. Informant's Name/Relationship (Type, Print)

Janice Fletcher-Grandchild

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

248 Friendship Rd Friendship MD 20758

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Moses Cemetery

Date

9-18-00

20c. Location - City or Town, State

Lothian, Maryland

21. Signature of Funeral Service Licensee

J.B.M.

22. Name and Address of Facility

J. B. Jenkins Funeral Home

7474 Landover Rd Landover MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Prostate Cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

Dr. Charles Judge

29c. License number

DZ9657

29d. Date signed (Month, Day, Year)

9/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Charles Judge 10845 Town Center Blvd #204 Dunkirk, MD 20754

31. Date filed (Month, Day, Year)

SEP 15 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 30500

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Susie A. Belt

2. Date of Death  
Month Day Year  
September 6, 20003. Time of Death  
3:30 A.M.Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Crescent Cities Center

4b. City, Town, or Location of Death

Riverdale

4c. County of Death

Prince George's

5. Social Security Number

579-48-8568

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

4/18/09

9. Birthplace (State or Foreign Country)

Huntsville, Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

P.G.

10c. City, Town or Location

Capitol Heights

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

901 Minna Avenue

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

3rd

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Ignatius Queen

18. Mother's Name (First, Middle, Maiden Surname)

Jane Brook

19a. Informant's Name/Relationship (Type, Print)

Margaret Markham/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

901 Minna Ave., Cap. Hgts., Md. 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Mt. Olivet Cem.

Date

9/11/00

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

H.S. Washington &amp; Sons Co., Inc.

4925 Burroughs Ave., N.E., Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia  
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Y/S

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41978

29d. Date signed (Month, Day, Year)

9-6-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. J. M. D. #1 Hosp Dr cheng m D 20785

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 11 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



